GOVERNMENT OF
NEWFOUNDLAND
AND LABRADOR

Working Together

for Mental Health

A Provincial Policy Framework for
Mental Health & Addictions Services
in Newfoundland and Labrador

October 2005

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We would like to dedicate this document in memory of

John Collins

a mental health consumer representative and team member

who was integral in the creation of this policy framework.

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INTRODUCTION

Slowly there is growing understanding of the critical importance of mental health and its influence at the individual, family and population levels. Not only is the true extent of the disability caused by mental illness becoming clear but its value as a resource to population health and wellness is more apparent. Any effort made at any level to affect change in the health behaviors of people and improve quality of life is strengthened when mental health is addressed as part of the approach. Successful wellness interventions emphasize that interconnection.

There is no health without mental health.

Although it is accepted that the general health of a population is largely determined by the social and environmental conditions of the community, that same realization about mental health has been slower to be acknowledged. Mental health is extremely sensitive to many societal stressors such as unemployment, poverty, homelessness and violence. These risk factors can foster mental illness and addictions, conditions which often cause major disruption in education, employment and social relationships. This results in isolation, poverty, unemployment and homelessness which ensures that the illness cycle continues. It can and has been a vicious circle for many.

In the 1960s and early 1970s individuals with mental illness were institutionalized, while those with addictions were treated separately. Even those with alcohol addiction were treated separately from those with drug addiction and many also had a concurrent mental illnesses in addition to other medical problems. All suffered from stigma and social isolation as a result of their illnesses. Today, addiction disorders such as substance abuse and gambling are considered to be a form of mental illness along with the traditional mental disorders like depression, anxiety or schizophrenia. Thus, this Policy Framework is intended to incorporate all levels of addictions, mental illness, and other mental health conditions, such as bereavement and relationship issues. It also responds to current best practices which promote the integration of addictions and mental health services so that the needs of individuals, families and communities can be met within a larger, more holistic context.

The personal, social and economic burden of mental illness and addiction is enormous. According to the World Health Organization (2002) it is estimated that, in terms of negative effect on life, five of the ten leading causes of disability in both developed and developing countries are mental illnesses. In fact, for males, depression and alcohol dependence are two of the top three causes of disability (Mathers, Vos, Stevenson & Begg, 2001). Given that between 18 and 24 percent of Canadians will experience a mental illness and that an additional 12 percent participate in harmful or hazardous drinking (Center for Addictions and Mental Health, 2000) the impact of this disease category on society is staggering. The Canadian Mental Health Association (2002), for example, indicated that mental illnesses and addictions were among the ten most common billing items for family practitioners in Canada. As well, it has been estimated that the economic burden of these conditions costs Canadian business in the order of fourteen billion dollars per year in lost productivity (Scientific Advisory Committee, 2002).

Anxiety, alcohol dependence and depression are the most common mental health disorders among adults. The estimated one year prevalence rate of anxiety disorders is 12 percent, depression is five percent and schizophrenia is 0.3 percent (Health Canada, 2002). According to the Canadian Community Health Survey (2002) the prevalence rate for alcohol dependence is about eight percent while that of problem gambling is 0.5 percent. For children, limited Canadian data indicate a prevalence rate of three to five percent for attention deficit hyperactivity disorder and five percent for conduct disorder (National Institute of Mental Health, 2000).

THE SCOPE AND AIM OF *WORKING TOGETHER FOR MENTAL HEALTH*

Working Together For Mental Health is the health and community services system's response to the long acknowledged challenges faced by those who use the mental health and addictions system. It is an attempt to lay out the essential changes and resources needed to create a dynamic, responsive system. The Policy Framework was created based on events, reviews and other initiatives over a number of years and culminated with an intensive year of province-wide consultation, deliberation and debate. It is based on a vision outlined in the 2001 framework document *Valuing Mental Health* (see Appendix A) that promotes a comprehensive system of primary mental health and specialized services. Its major goal is improvements in the mental health status of those who use mental health and addictions services, as well as for the general population.

Working Together For Mental Health is intended to cover the full continuum of mental health and addictions services. It addresses all age groups and emphasizes the importance of strong connections between all levels of service. It also recognizes the important linkages to other initiatives such as the provincial wellness plan, primary health care renewal and emerging work in long term care. It takes into account regional and geographic variations, as well as current and future projected demographic realities. The proposed service accessibility model emphasizes smooth transition between all levels of intervention and recognizes the importance of sel-help, mutual aide and family support. An indicator framework will measure the implementation of the Policy Framework, as well as its impact. Full implementation of the framework is a long-term commitment that will take some years to be realized.

The title, ***Working Together For Mental Health***, illustrates three different perspectives on how the system must operate in order to make things better for consumers and others. First, this is the only provincial policy framework that has been developed to date for mental health and addictions services. All regions have been involved in its development and continued effort will ensure this Policy Framework is successful in strengthening services for consumers, families and communities.

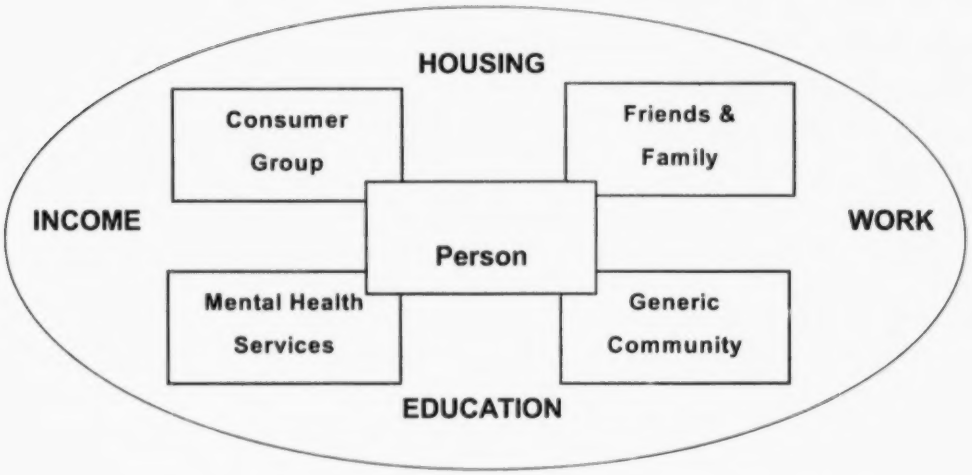
Second, the mental health and addictions system will have an opportunity to work closely with the emerging primary health care teams. This will help create an integrated system and solid basis for the delivery of primary mental health care. A third and critical component, is the collaborative provision of mental health and addictions treatment between primary mental health care service providers, specialized addictions/mental health service providers and consumers, families and communities. The integration of these important service areas, in collaboration with consumers, is recognition of the often co-occurring nature of mental health and addictions problems and the benefit of intervening comprehensively when possible.

The Policy Context and Community Resource Base Model

There has been an international movement to promote mental health in light of the increased understanding of the toll that mental illness and addictions take on individuals, families and communities. The World Health Organization (WHO) has been instrumental in bringing attention to the need for more intensive prevention efforts, even in cases of psychoses. Countries such as Australia, the United Kingdom, New Zealand and the United States have released national mental health plans in the past five years. These plans are similar in that they focus on improving the mental health status within communities and ensuring responsive mental health and addiction systems that involve consumers, their significant others and families.

In Canada, there has been recognition of mental health needs through the Kirby (2002) and Romanow (2002) reports, although no national plan has been created. Activity is occurring, however, and, in particular, there has been a proliferation of shared mental health care arrangements between family doctors, psychiatrists and mental health/ addictions counselors. Evaluations (Kates and Ackerman, 2002; Malcolm, 2000; Kates, 1999) show considerable benefits for consumers, families and service providers from more effective collaboration. These benefits are especially important as the federal government is providing primary health renewal funding to all provinces and territories at a time when Newfoundland and Labrador is developing a comprehensive mental health and addictions services policy framework. Grounding the Policy Framework in primary health care will help ensure that the mental health needs of the population are met in an effective, efficient manner.

The Community Resource Base Model



The Policy Framework recognizes that mental health services belong primarily in the communities where people live. However, the model of the Community Resource Base (see following page) (Canadian Mental Health Association, 1993) in *Valuing Mental Health* shows that it takes much more than clinical services, either in the community or in hospital, to meet a person's mental health needs. It points to the importance of other community and informal resources: family caregivers, self-help support groups and generic community activities (such as churches, social and recreation groups), as well as income, housing, education and work. The provincial Policy Framework, while mainly focused on one component of the Community Resource Base Model - the mental health and addictions system - includes and is designed to complement and work in harmony with the other elements.

The Provincial Consultations

The voices of consumers and families spoke powerfully on the themes of the Community Resource Base Model during the consultations on the Policy Framework. From consumers, the message was loud and clear: clinical services are vital when ill but community supports and opportunities are needed to stay well. Housing was a top priority. People also wanted meaningful employment - something lacking in many communities. The barriers for many were intensified by what they felt were restrictive income support policies. Funding for transportation was a major issue, especially in rural areas, as was the drug card policy which prevents both consumers and their spouses from

earning to their potential. As one consumer put it, "My drugs cost $1,000 a month. Ironically, I can't afford to work."

Family members likewise stressed that social support and participation in community life was as important as clinical services. From their point of view, the number one priority was the inclusion of the family as part of the care team. They consider family support as key to the individual's recovery. However, many described situations where, on the grounds of confidentiality, they had been denied information they needed to understand how to help their loved one, particularly when they were providing a home and aftercare.

Many consumers and family members saw connections with self-help networks as vital. Mutual support among people who share similar experiences is the most powerful way to diminish the sense of isolation and stigma. Coming together in self-help groups strengthens people's capacity to identify their needs, advocate on issues that are important to them and experience a rich source of information for learning purposes. Consumers and family members of self-help groups are better able to participate in the policy and planning processes that shape the future of services in their communities and regions. As they stated during the consultations, "We are the people directly affected. We know what we need, and we need to be involved in decision-making both about our own care and the planning of services."Self-help, however, does not happen without adequate leadership and organization. The Schizophrenia Society of Newfoundland and Labrador, the Canadian Mental Health Association Family Support Group and the Early Psychosis Family Support Group are three examples of family self-help groups. However, a 'critical mass' is needed to enable an effective group to be formed, and in this respect again the geography of the province is a challenge. CHANNAL, the Consumers Health Awareness Network of Newfoundland and Labrador, does operate self-help groups in all regions, and family support networks have also been growing in the province in recent years. Alcoholics Anonymous, Al-Anon, Narcotics Anonymous and Gamblers Anonymous groups are also available to individuals to some degree throughout the province.

THE PROVINCIAL POLICY FRAMEWORK: *WORKING TOGETHER FOR MENTAL HEALTH*

Working Together For Mental Health is organized according to five main policy directions that are the underpinnings on which improvements to the mental health and addictions system are made. Together, these five directions provide a solid foundation for both enhancement of the mental health status of the population and better clinical outcomes for consumers and families. The five policy directions support best practices and reflect current thinking and evidence in the mental health and addictions system. They are consistent with the Community Resource Base Model and were derived from extensive literature reviews and provincial consultations with system stakeholders.

PROVINCIAL POLICY DIRECTIONS

I **Prevention and early intervention**

- Mental health and addictions prevention and early intervention approaches will be in use throughout the province.

II **Consumers and significant others**

- Consumers, families/significant others will be involved in care and treatment decisions affecting them and have opportunity to participate in system-wide planning and evaluation.

III **Bridges for better access**

- Strong program connections among all components of the mental health and addictions system, the broader health system and the community will facilitate the provision of timely and appropriate services.

IV **Quality mental health and addictions services**

- Mental health and addictions services and programs will be based on current evidence and reflect best practices in the field.

V **Demonstrating accountability and measuring progress**

- Meaningful indicators regarding quality mental health and addictions services and population mental health status will be publicly available.

POLICY DIRECTION ONE:
PREVENTION AND EARLY INTERVENTION

Real change in the mental health status of the people of the province will only happen when society takes responsibility for improving mental health and preventing addictions and mental illness. A responsive mental health and addictions system has to actively lead in prevention and early intervention approaches while supporting communities in the promotion of mental health. This means that the service system has to fairly distribute its resources (human and other) to include population focused interventions that are not clinical in nature. Designing and implementing mental health prevention and early intervention initiatives that build social networks, promote and support community capacity building and use a combination of methods to strengthen individuals, families and communities will have far reaching impacts beyond what the clinical component of the system can offer.

POLICY: Mental health and addictions prevention and early intervention approaches will be in use throughout the province.

Implementation of this policy direction will take a variety of forms. The policy is intended to foster ongoing efforts at government, health authority and program levels to build a climate and develop expertise within the system to increase both the attention and value given to population approaches for mental health and addictions prevention and early intervention.

Approaches that support implementation of the policy could include (but are not limited by):

- Community development and education activities that are sustained and improved over time.
- Development, use and evaluation of primary mental health and addictions prevention programs and materials.

- Development of a strong mental health focus in all child health programs.
- Consistent policy development across community and government agencies on issues that impact on individuals' mental health.

POLICY DIRECTION TWO: CONSUMERS AND SIGNIFICANT OTHERS

Consumers and their significant others play a far greater role in mental health care and treatment than ever before. The person/family receiving services must be the central focus of any intervention. Consumer knowledge, expertise and leadership are key components of the mental health and addictions system. The active involvement of the person directly affected by the illness strengthens consumer and family satisfaction, often improves long-term clinical outcomes and capitalizes on the value of experiential knowledge.

The term *consumer*, rather than *patient*, is used to signify an active role in self-care and to reflect the right to choice of services, the right to complain if a service is not adequate, and the right to be consulted when new services are being designed, implemented and evaluated. Self-help organizations such as Consumer Health Awareness Network of Newfoundland and Labrador (CHANNAL), and the Schizophrenia Society of Newfoundland and Labrador have been active voices for change and progress in the delivery of mental health services in the province. In the addictions field, self-help has a long history of proven effectiveness. Although Alcoholics Anonymous (AA) as an organization does not engage in advocacy, many individuals who have participated in AA have become active in public education. Participation in self-help is often the foundation upon which advocacy and consumer empowerment is built.

POLICY: Consumers, families/significant others will be involved in care and treatment decisions affecting them and have opportunity to participate in system-wide planning and evaluation.

Active involvement of individuals and caregivers in taking charge of their health and well being is critical to successfully managing a potentially debilitating disease. All activities that encourage the participation of consumers in the mental health and addiction system are reflective of this policy direction.

Approaches that support implementation of the policy could include (but are not limited by):

- Mental health and addictions programs that have written policies and procedures that identify the ways and opportunities that consumers and families can become involved.
- Self-help initiatives that are supported and promoted by the service system.
- Acknowledgment of, and support for, the role families and caregivers play in facilitating the health and well being of individuals with mental illnesses including addictions.
- Families that are actively supported to maintain their own well-being while in the care giving role.
- Sustained community capacity building that is directed at maximizing the potential of consumer and family self-help and in facilitating the involvement of other community resources.

POLICY DIRECTION THREE: BRIDGES FOR BETTER ACCESS

One of the most frequently identified difficulties with the mental health and addictions system relates to the ongoing fragmentation that characterizes its operation. There are limited or

ineffective connections between the essential components of the system itself and between the system and other health and community services and supports. Often it does not function from a person-centered perspective and consequently, consumers, families and entire communities have voiced their dissatisfaction. Mental health providers have also expressed frustration with a system that does not effectively respond to the changing clinical needs of the population.

Developing a diverse approach to establishing relationships and connections across the mental health and addictions system is a priority for the success of the provincial Policy Framework. Both formal and informal agreements that clearly identify the roles and responsibilities of the various elements of the system will be encouraged. The recent creation of four Regional Integrated Health Authorities that has placed responsibility for the full range of mental health programming (including addictions) under the same authority will be a great foundation for implementing this approach. As primary health care organizations continue to be established, service agreements will facilitate new and better ways of working and moving throughout all levels of the system

POLICY: Strong program connections among all components of the mental health and addictions system, the broader health system and the community will facilitate the provision of timely and appropriate services.

The aim of this policy is to appropriately provide the services and supports that individuals and families need to effectively recover, improve and maintain their mental health. The nature of mental illness and addictions often necessitates a comprehensive team approach that involves access to a variety of treatment and support interventions. No one service is usually adequate to meet the diverse needs of this population. Cooperation and collaboration among a range of service providers is essential.

Approaches that support implementation of the policy could include (but are not limited by):

- Mental health and addictions collaborative program design, development and delivery.
- Mental health and addictions service developments that utilize the model on the following page to improve accessibility.

- The establishment of Regional Interdisciplinary Teams in each of the four health regions to provide the critical connections among the various components and levels of the mental health system.
- Strengthened partnerships with mental health and addictions organizations such as the Canadian Mental Health Association, Alcoholics Anonymous, CHANNAL, Gambling Anonymous, Al-Anon, Narcotics Anonymous, Schizophrenia Society of Newfoundland and Labrador, and other local groups.

Service Accessibility Model

Programs for Specific populations
Specific populations may include: children, seniors, those with brain injuries, those with severe and persistent mental illness.
Regional Specialized: Acute Inpatient & Community Treatment
Includes: prevention, early intervention shared care ++
Primary Mental Health Care Including Case Management & Addictions Treatment
Self Help & Mutual Aid
Self Help & Family Support

POLICY DIRECTION FOUR:
QUALITY MENTAL HEALTH AND ADDICTIONS SERVICES

Significant progress has been made in the past several decades to establish a solid evidence base for a variety of treatments and interventions within the mental health and addictions field. Research has accumulated which demonstrates the benefits of various mental health treatment approaches. For individuals with serious mental illness, for example, strong scientific evidence illustrates that the most effective services combine optimal medication management with psychosocial interventions that provide the consumer and family with information about the illness, ongoing supports and rehabilitation. In situations of mild to moderate depression, collaborative (shared-care) approaches involving primary care (physician) services and mental health expertise, have proven more effective than primary care alone. In addition, cognitive-behavioral and interpersonal therapies have been found to be effective in treating symptoms of depression. For children with significant mental health conditions, such as conduct disorders, an intensive home and family focused approach known as Multi-systemic Treatment consistently produces desired results. For persons with addictions, behavioural relapse prevention has proven successful while community reinforcement strategies focused on improving social functioning are also valuable. For some individuals with addiction problems, careful use of prescribed medication such as methadone and other anti-craving drugs has proven successful.

POLICY: Mental health and addictions services and programs will be based on current evidence and reflect best practices in the field.

The aim of this approach is to ensure that the mental health and addictions programs and services offered to individuals and families are of the highest quality and will reap the greatest benefits.

Approaches that support implementation of the policy could include (but are not limited by):

- Integration of community mental health and addiction services into primary health care organizations, each with a sustainable plan for the provision of an array of primary mental health and addictions services, including:
  - Intake coordination, assessment, treatment (including counseling and various individual, family and group therapies) and follow-up care for children, youth, adults, seniors and their families with addictions, mental illness and mental health problems.
  - Consultation processes and shared-care arrangements.
  - Case management for individuals of all ages with severe mental illness and/or addictions.
  - Home support/supportive care services.
  - Emergency mental health services, including mobile crisis response.
  - Program support for consumer self-help and family caregiving

  (Appendix B provides a brief description of some of the types of programming that primary health care organizations may provide).
- Establishment of a range of community-based, best practice, specialized mental health/addiction services in each region that best meets the needs of the population. This could include:
  - Exploration and implementation of alternatives to hospitalization when intensive services are required to intervene in an acute illness episode. A number of approaches has been proven effective including psychiatric home care and assertive community treatment when complex needs and multidimensional illnesses are at their height. The table on the following page lists some of the alternatives to hospitalization that will be explored and implemented by Regional Integrated Health Authorities depending on regional characteristics.

REGIONAL ALTERNATIVES TO INPATIENT HOSPITALIZATION
Types of Programming

1. Acute mental health home care
2. Day hospital services - larger centers
3. Withdrawal management programs
4. Early psychoses intervention
5. Assertive community treatment
6. Processes for quick access to specialized assessment and treatment decisions

- Development of acute Community Mental Health and Addictions programs on a regional basis to assist individuals and families to manage and recover from addictions and other mental illnesses. Withdrawal management programs are a clear illustration of the need for integration of specialized addictions services with other health and community supports. Effective and safe home detoxification programs should be developed that are characterized by: staff expertise in detoxification, support from AA and Al-Anon, home support for family and children, involvement of family physician, partnerships between formal and voluntary sectors, adherence to accepted guidelines and standards for withdrawal management through partnerships with AA, Al-Anon, Narcotics Anonymous and Gamblers Anonymous, and, an information kit for schools.

❑ Ongoing availability of acute Inpatient Mental Health/Addictions Treatment Services as needed for residents in the province.

- Provincial guidelines will be developed to support effective use and monitoring of this service. The following table identifies the number and distribution of specialized mental health and addictions beds in the province as of Spring 2005. Acute care beds (situated on mental health/psychiatric units) for adults comprise about 43 percent of all dedicated beds while the more specialized beds (i.e. those for specific populations, such as children, older adults, those with severe and persistent illness) account for 41 percent or 131 beds. Specialized addictions beds comprise about 16 percent of the total beds although it is worthy to note that treatment of substance abuse is a common occurrence within the acute inpatient care system as well.

Dedicated Acute and Tertiary (Specialized) Mental Health Beds

Beds	EASTERN (includes St. John's)	CENTRAL	WESTERN	NORTHERN (includes Labrador)	TOTAL
Acute care	90	20	25	N/A	**135**
Tertiary care	131	N/A	N/A	N/A	**131**
Addictions	Recovery Center	N/A	Humberwood	Aboriginal Treatment	**~50**
Total beds					**316**

- Development and/or expansion of specialized living and community supports for individuals with serious mental illness and/or addictions.
  - Educational and vocational opportunities make a critical contribution to the successful recovery from serious mental illness. Often with minimum support and accommodation, individuals suffering from difficult illnesses can experience success and a renewed sense of hope when provided with skill building experiences. System efforts to increase these kinds of opportunities for consumers will be ongoing.
- Provincial mental health and addictions programs for specific populations that are designed for regional accessibility and, wherever possible, regional delivery.
  - Long term institutional placement is no longer an acceptable care option for individuals with severe and persistent mental illness. Community integration is the goal with treatment and other supports provided from a community base. Helping individuals live full and productive lives is best accomplished in their natural environments where the social network can be strengthened and maximized.

POLICY DIRECTION FIVE:
ACCOUNTABILITY AND MEASURING PROGRESS

The greatest resource within mental health system is the people who choose to receive and provide services - consumers, families, clinicians, managers, physicians and others. In order to implement ***Working Together For Mental Health*** in an effective manner, continued involvement is needed by all participants. While the five policy directions provide solid parameters for system and program development, many essential decisions are still required at the regional and local levels. The 'what and how' of program delivery will be heavily influenced by regional characteristics and other factors that impact service provision. Every region will have a different set of requirements in order to implement the Policy Framework. Some regions will require more resources than others. In some areas redeployment of staff may occur to initiate new programs.

Having a way to keep track of all the activity and progress related to the Policy Framework will be an important element of the system's accountability. Monitoring how resources are used and what outcomes are achieved will help with the ongoing improvement of the mental health system. Open communication among all involved will be critical to a successful process.

POLICY: Meaningful indicators regarding quality mental health and addictions services and population mental health status will be publicly available.

The aim of this policy direction is to demonstrate the system's commitment to quality mental health and addiction services that help people achieve their maximum health. It recognizes that a dynamic, responsive system must continually adjust and adapt to changing needs and environments.

Approaches that support implementation of the policy could include (but are not limited by):

- A provincial implementation plan, developed in conjunction with the Health Authorities, that identifies the resources (human and other) required to implement the policy framework over the longer term.
- Implementation of a provincial indicator framework to measure progress and provide results for public release.
- Establishment of a systematic process to enhance education and training among all stakeholders.
- Provincial coordination of a system-wide effort that promotes greater awareness of the impact and importance of mental health. The establishment of the new Division of Mental Health and Addictions within the Department of Health and Community is one important step in this direction.

WORKING TOGETHER FOR MENTAL HEALTH
SYSTEM-WIDE ISSUES

Although the five major policies that comprise **Working Together For Mental Health** provide the mental health and addictions system with a solid foundation on which to operate, a number of specific system issues are worthy of note for Newfoundland and Labrador. Identification of the need for focused attention in the areas of (I) special populations; (2) mental health legislation; (3) telehealth, and (4) human resources resonated throughout the provincial consultations.

SPECIAL POPULATIONS

Children and Youth

Children are at greater risk than adults for developing a mental illness. It is consistently verified that one child in five suffers from a mental health or substance abuse disorder, yet the majority of children do not receive effective and appropriate treatment. The expert think tank that was convened to provide advice and guidance to the developing mental health plan (See Appendix C) was clear about the service directions that the Policy Framework should facilitate:

- the establishment of additional programs across the spectrum of prevention, early intervention, treatment and support interventions;
- mechanisms to 'shore up' the capacities of families, schools and communities to address the impact of mental illness and/or addictions in children;
- system processes to better coordinate services, monitor outcomes and demonstrate accountability. The Newfoundland and Labrador Model for the Coordination of Services for Children and Youth was identified as the appropriate coordination process; and
- development of provincial networks among service providers and other stakeholder groups to promote quality, strength and consistency among programs.

Serious Mental Health Disorders in Children and Youth

- Adolescent Gambling
- Adolescent Substance Abuse
- Adolescent Suicide
- Asperger's Syndrome
- Anxiety
- Attention Deficit Hyperactivity Disorder
- Autism and other Pervasive Developmental Disorders
- Bipolar Disorder
- Depression
- Disruptive Behavior Disorders
- Eating Disorders
- Learning Disabilities
- Schizophrenia
- Sleep Deprivation
- Tics and Tourette's

(World MH Day 2003)

Timely access to an array of evidence-based assessment and treatment services was the 'hue and cry' from the provincial experts. Early identification of pending problems is worthless if not followed by an appropriate response. The following table summarizes the range of services recommended for children and youth.

Program	Description
Primary Prevention	Approaches aimed at decreasing risk factors and promoting resilience in select populations. Requires linkages and connections among community agencies and children's mental health programs.
Consultation	Has a number of forms including direct clinical contact with referred clients as well as case consultation between professionals and professional development activities. Vital to the viability of primary mental health care.
Community and Home Support	A range of activities and services for children youth and families that promote quality of life. Includes respite, both scheduled and other, for families of children with serious mental health needs.
Crisis Services	Community team-based approach offering intervention in multiple locations.
Inpatient/Residential Treatment	Short term crisis stabilization (less than one week) or longer term diagnostic work up. Combination of regional and provincial delivery.
Day Treatment	Alternative to hospitalization or part of discharge plan for transition back into community .
Case Management	Model of Service Coordination.

Women

Gender is a critical factor in mental health and mental illness. It determines the degree or magnitude of power and control that women and men have over the socioeconomic determinants of their mental health, their lives, their social position and their susceptibility and exposure to mental health risks. Risk factors that create specific, additional challenges for women and their mental health include gender based violence, low income and income inequality, low or subordinate social status and the unremitting responsibility for the care of others. Although the overall rates of psychiatric disorder are almost identical for women and men, illness patterns are very different. Most notable are the gender differences in the rates of common mental disorders such as anxiety, depression and somatic complaints. These disorders, which affect approximately one in every three adults in the community, are predominately experienced by women. Depression, for example,

is twice as common in females as it is in males while alcohol dependence is the opposite. Although there are no marked gender differences in the rates of the more serious mental illnesses such as schizophrenia and bipolar illness (which affect less than two percent of the population), other aspects of these conditions vary with gender. Age of onset of symptoms, frequency of psychotic periods, social adjustment and long term outcomes all appear to favor women.

Clear differences are evident between the sexes in terms of their patterns of help seeking for mental health problems. Women are more likely to seek help from and disclose mental health problems to their primary health care provider while men tend to seek specialist care and use inpatient services more frequently. Gender bias also occurs in the provision of treatment. Doctors are more likely to diagnose depression in women compared to men even when they have identical symptoms. By far, women receive more mood altering psychotropic drugs.

In order to address the disparities in mental health that exist between the genders action on many levels is recommended. The World Health Organization (2000, pp.17-19) first suggests that mental illness and associated risk factors be socially contextualized. To view mental illness as simply a disease of the brain limits the range of interventions that can make real differences in the lives of those affected. Other approaches include:

- education and training to improve the detection, treatment and referral of mental health disorders in primary health care settings;
- reduction of gender based barriers to mental health care including access, bias and discrimination;
- a public health approach to improve primary prevention and address gender specific risk factors;
- incorporation of a mental health focus in all programs related to child health.

Older Adults

Current service delivery models do not reflect the complex and changing mental health needs of older adults. Mental health and behavioral problems associated with senior's mental illness and/or addictions are not a natural part of aging and much can be done to prevent deterioration, restore health and enhance quality of life. Ageism and stigma, however, interfere with a senior's ability to seek and receive mental health services. One of the consistent themes that arose from the expert

think tank on the mental health of older adults is the need to integrate mental health care with physical health care. As one of the most vulnerable populations for mental health problems is the group with chronic physical conditions, efforts to identify depression, anxiety and other conditions are mandatory.

Dementia and delirium pose special risks for older adults. In nursing homes, where it is estimated that as high as 90 percent of the population has a mental illness, behavioral and psychological symptoms of dementia create challenges for staff and other residents (Brodaty, Draper and Low, 2003). Poly-pharmacy, an all too common reality for seniors, is known to trigger delirium.

Support for the mental health of older adults will be maximized if seniors can live their final years as close as possible to the life they always knew. A solid range of home support and outreach services are the backbone to the implementation of this policy direction. Services that promote independence and enhance quality of life for older adults include: supported housing options, home care not dependent on physical disability, bereavement counseling, day programs, home maintenance and others. Family support services are also an essential component of senior's mental health. Healthy family relationships are maintained through the availability of ongoing assistance in the form of accurate and responsive assessments, a variety of respite options, subsidization, care for caregivers and supportive counseling.

Continuing links to the new Division of Aging and Seniors within the Department of Health and Community Services and the development of the Long-Term Care and Supportive Services Plan will help set the provincial Policy Framework for this client group. Bringing mental health issues to the forefront of that initiative will be beneficial to consumers and families alike.

Aboriginal Peoples

As with all Canadians, social, economic and environmental conditions have had a profound effect on the health of Aboriginal Peoples (Canadian Institute for Health Information, 2004, p.75). Factors such as treaty negotiations, loss of land to settlers and the organization of power and governance are identified as having significant impact on their lives and health. Given the importance of cultural identity to aboriginal health and well being, it is not surprising that the health status measures of Aboriginal Peoples are worse than those of the overall Canadian population. For example, current

national indicators demonstrate that, on average, First Nation and Inuit Peoples live five to ten years less than Canadians, have infant mortality rates well above the Canadian norm and experience premature death from injuries at a rate four times that of the Canadian population as a whole. The leading causes of death due to injuries for aboriginals under age 45 are motor vehicle accidents, suicide, drowning and fire.

The unique experiences and culture of Aboriginal Peoples including the high incidence of suicide, substance abuse, fetal alcohol spectrum disorders, violence and family and band breakdowns necessitates a customized response to mental health issues in this population. Culture, language and tradition are integral to the view of health held by Aboriginal Peoples (Canadian Institute for Health Information, 2004). Traditional mental health and addictions services are not viewed as an effective way of improving aboriginal circumstances. Holistic approaches that create balance and harmony between the physical, spiritual and emotional components of life need to be emphasized. The fragmentation that characterizes the current service delivery system with various elements provided by either the federal, provincial or aboriginal levels of government works against the health of Aboriginal Peoples. In spite of many efforts there has been little success in harmonizing the provision of mental health services across the three levels. Individuals are often required to access each level separately.

As aboriginal communities take more and more responsibility for self government, relationships with provincial and regional services will also evolve. The Labrador-Grenfell Health Authority oversees the service requirements for the north. Aboriginal leaders and others will be active participants in determining the nature and level of mental health services to be delivered by the province.

MENTAL HEALTH LEGISLATIVE CONSIDERATIONS

The *Mental Health Act* is a difficult and controversial statute. It is the legislative framework upon which decisions can lawfully be made on behalf of those adults who, because of reasons of severe mental illness, are unable to make decisions for themselves. It is the only legislative authority, apart from the criminal code and related statutes, that allows the detention of individuals against their will. In Newfoundland and Labrador, there are approximately 500 occasions in any one year when an individual is involuntarily admitted to a psychiatric service under the *Mental Health Act*.

There are that many occasions again when an individual is detained in the community, usually by police, for a psychiatric assessment but is found not to require admission and is released.

The *Mental Health Act* is nearly 35 years old and reflects a different era in the health system. It was developed when patient/consumer rights were not a paramount issue and the range of mental health treatment options were limited. Because the legislation has not kept pace with improvements and developments in the mental health field, the framework is inadequate. Other comparable jurisdictions (provincial and national) reformed their legislative frameworks 15 to 20 years ago. There is a clear need, then, to redesign and implement a new Act which is based on current evidence and clinical practice standards and respects the individual's autonomy and decision making ability.

A new legislative framework is an essential element of a comprehensive mental health plan. It addresses one of the most serious situations encountered within the system and often affects the most severely ill. A provincial Mental Health Legislation Stakeholder Committee, which has been in place for four years, has the groundwork completed to create a new statute. The recent judicial inquiries into the sudden deaths of two men experiencing psychiatric crises emphasized the importance of new legislation. Thus, it is timely to renew our commitment to the development of this legislation in order to facilitate appropriate consultation and thorough debate on a new Act. A time frame of two years is suggested for proclamation.

TELEHEALTH

Telehealth technology is gaining momentum as a viable way to provide direct mental health services to consumers and their families as well as training and consultation to mental health service providers. The province has a well-developed telehealth system that is continuously improving in quality. It includes both video and audio conferencing and has been successfully used for child and adult mental health consultations, including psychiatric assessment of individuals in remote areas to determine certifiability under the *Mental Health Act*. It has great potential to be an important 'connector' within the system but widespread use has not yet occurred. Factors such as personal comfort with the technology and poor quality of the video transmission appear to be issues inhibiting use (Cornish et. al, 2003). With the recent amalgamation of the regional health boards, health regions have expanded and issues of equity of health service provision are coming to the

forefront. Telehealth can play a vital role in addressing accessibility concerns as distance is no longer a barrier and efficiency is enhanced by maximizing professionals' time.

Networking among stakeholders in the mental health and addictions system needs strengthening throughout the province. Mental health is but a small sub-system of a much larger, technologically sophisticated health system that spans the same massive geography. The small numbers and geography lend themselves perfectly to telehealth as a vital part of consultation/shared care and a critical link in ensuring that individuals residing in rural and remote areas of our province have access to needed mental health services. The potential use of telehealth will be further explored as the Policy Framework is implemented across the province.

HUMAN RESOURCE ISSUES

A number of health human resource issues will require ongoing attention by the mental health system. In particular,

- Concern related to the potential loss of specialized addictions knowledge and skill when mental health and addictions programs integrate. Provincial standards and system incentives have been suggested to encourage education and training, establish core competencies and promote development of a certification process for addictions counselors. The development of consultation networks for addiction experts to share their knowledge has also been suggested.
- Retention and recruitment of professionals from core mental health disciplines especially psychologists and occupational therapists are particular challenges. Mental health and addiction program managers have expressed interest in the development of a human resource plan for the system. The newly established Division of Mental Health and Addictions will have a strong leadership role in this regard.
- Ongoing program development issues such as provincial skill mix guidelines for new programs such as rural case management and crises services. Mechanisms will need to be fostered to continue the development on a number of program areas.

CONCLUSION

Mental health reform has been occurring in most provinces and territories since the early 1990s. The principles of community-based mental health care have been accepted and followed wherever possible, such as, providing treatment in the least restrictive setting, involving individuals and families in care and treatment, and creating a continuum of service based on best practices to meet mental health needs. Like other jurisdictions, this province is challenged to provide quality, accessible, and flexible services that meet the mental health needs of our population.

The Provincial Policy Framework, ***Working Together For Mental Health***, is designed to address the mental health needs of the population of Newfoundland and Labrador. The continued involvement of consumers, families and communities working together with service providers will ensure the development of the best possible mental health and addiction services for our province. Working together to promote mental health and reduce addictions and other mental illnesses is key to positive change in our population's mental health.

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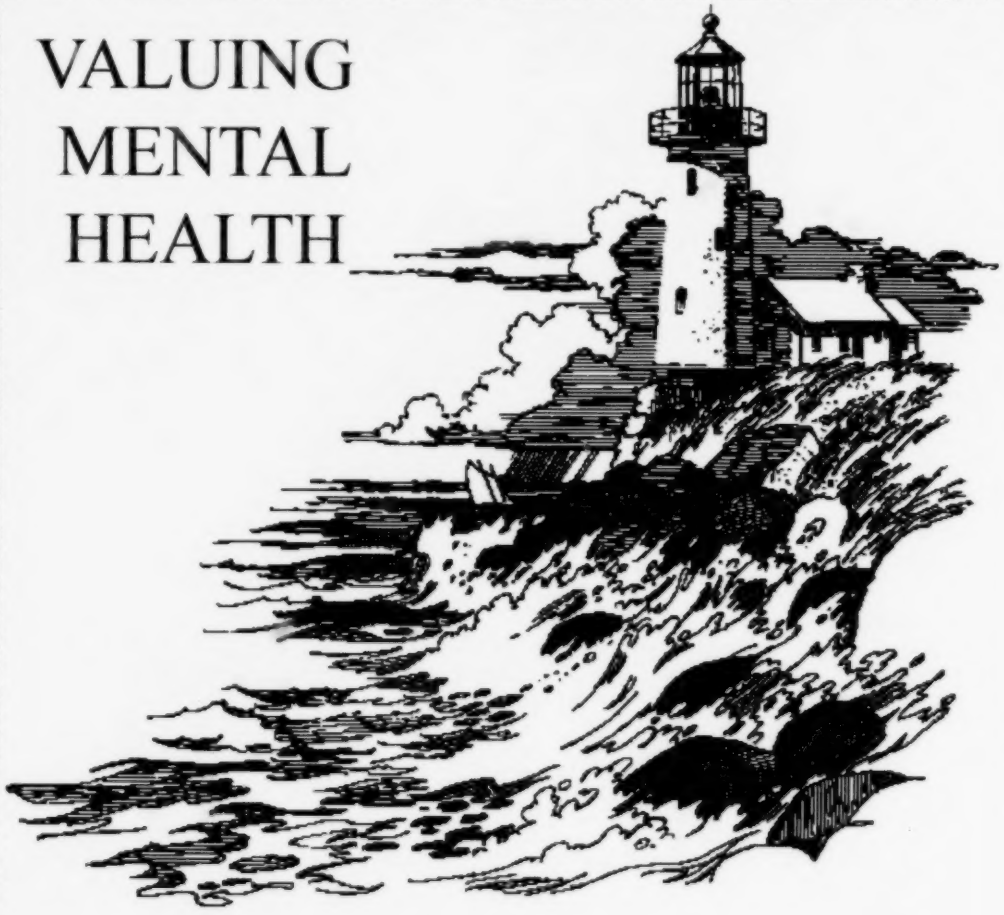
APPENDIX A

Valuing Mental Health (2001)

VALUING MENTAL HEALTH



A FRAMEWORK
TO SUPPORT THE DEVELOPMENT
OF A
PROVINCIAL MENTAL HEALTH POLICY
FOR
NEWFOUNDLAND AND LABRADOR

September, 2001

ACKNOWLEDGMENT

This paper represents the views and the efforts of a large number of individuals and groups with an interest in mental health. A broad based, consultative process, initiated by the Department of Health and Community Services in 1999, brought together a large number of stakeholders to explore and endorse major policy directions for the mental health system. The Newfoundland and Labrador Division of the Canadian Mental Health Association was contracted to develop a paper that captured the spirit and intent of these views and experiences. *VALUING MENTAL HEALTH* reflects the collective best wisdom of more than 100 individuals and organizations that provided input. It provides a solid foundation and insightful directions to achieving a mental health system that meets the needs of the residents of this province.

The contribution of all who participated in this process was significant and is greatfully acknowledged. In particular, the participation of mental health consumers warrants special mention. Without their generous involvement and willingness to candidly share their lived experience of mental illness this paper would have no basis.

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INTRODUCTION

Blair is an accountant in a successful firm. He is under tremendous work pressure because he is working to become a partner. In the last year he has felt a lot of anxiety, has suffered from insomnia, and has felt exhausted and inefficient at work. He sees little of his family, and relationships at home are strained. Blair always coped well with stress before, but now he feels he has lost control. His doctor tells him he is depressed, prescribes an anti-depressant and recommends sick leave. Through his firm's Employee Assistance Program, Blair is also able to get counselling for himself and his family to help them all understand and cope with this experience.

In August 1998, the Government of Newfoundland and Labrador introduced its Strategic Social Plan. The Plan lays out a new approach to issues of social well-being based on new ways of working together by government, communities and individuals. It calls for a shift away from crisis-driven responses towards "proactive approaches that effect long-term solutions." It states that "Wherever possible, policy development will stress the well-being of the whole population."

A proactive, population health and well-being approach is needed in mental health. Too often mental health is thought of simply as the absence of mental distress or disorder. Mental health, however, is not a narrow issue, of concern only to the users and providers of mental health services. It is an integral part of our overall health and well-being. We are all in a state of mental health - good, poor, or somewhere in between - and it affects every aspect of our lives.

As with physical health, we tend to take our mental health for granted until we have a problem: when we are over-stressed at home or at work; when we experience the loss of a job or a relationship; when worry or anxiety upsets our capacity to cope; or when we develop a mental illness. At such times we become aware of how important it is to have the right kind of support and services.

We are all potential users of mental health services, whether in the form of a family doctor, a counsellor, a support group or a psychiatrist. As with any health problem, only a small number will need intensive psychiatric care. However, the recovery and maintenance of good mental health involves more than service provision. It requires a much broader approach, one that applies to the whole population.

VALUING MENTAL HEALTH lays out some important policy directions to support the promotion and maintenance of mental health as well as for the care and treatment of individuals and families when mental health problems or illness occur. It identifies the need for informal community supports as well as for the professional service component. It makes the connection between the quality of one's mental health and the social determinants of health such as income, housing and employment.

The paper is intended as a resource for the future development of the mental health system. Its starts with the notion that mental health is a universal issue- a vital aspect of everyone's quality of life. It emphasizes the belief that mental health policy must be broad enough to encompass the mental health needs of all people across all age groups and specific enough to address the specialized complex needs of individuals with serious mental illness. It identifies a number of challenging issues for the system to address and outlines appropriate goals to be achieved.

UNDERSTANDING MENTAL HEALTH

What We Mean By Mental Health And Illness

It is important to make a distinction between **mental health** and **mental illness** or disorder. A widely accepted definition of mental health appears in **Mental Health for Canadians: Striking a Balance**, a federal government discussion paper published in 1988[2]. Mental health is described as the interaction between our individual characteristics and our environment, including home, family and friends as well as our involvement in the world of work and other community activities. Based on these factors, all of us exist at some point on a mental health continuum.

Mental Health

In a sense, mental health is like the weather: it is the emotional and psychological climate in which we live. Like the weather, it is affected by the systems moving through, sometimes fine, sometimes overcast, sometimes stormy. That is, mental health is our interaction with the context and events of our lives, critically affected by our life situation and the amount of support and control we have in dealing with our circumstances.

Factors Affecting Mental Health

Mental health is about coping with the challenges of life, and no one gets through life without such challenges, from bereavement to job stress to relationship problems. Strong support networks and financial security do a lot to help a person cope with mental health problems, whereas living in a situation of poverty or abuse, with little control over circumstances, places serious strain on mental health. Income, housing, education and employment - or the lack of these - are key factors affecting our sense of well-being. "Whatever makes it difficult for the individual, the group and the environment to interact effectively ... is a threat or barrier to mental health," which may result in a mental health problem.

Mental Illness

A mental disorder, on the other hand, is a medically diagnosable illness that results in the impairment of an individual's thoughts, mood and behaviour. The causes of mental illness are still not fully understood, but have much to do with our individual biochemistry, often complicated by psycho-social stresses which may act as triggers. Research points to a genetic factor in major disorders like schizophrenia, manic depression and major depression. Also, mental illnesses tend to be episodic or cyclical in nature; a person may have episodes of acute illness, but also long periods of wellness. So the mental illness continuum is about the presence or absence of symptoms of disorder.

Impact of Mental Illness

The impact of mental illness, however, goes far beyond the actual symptoms. As it involves changes in thought, feeling and behaviour, serious mental illness can disrupt a person's education, employment prospects and relationships. All too often those with the most severe illnesses find themselves living in poverty and isolation - circumstances which would be hard on anyone's mental health, let alone that of someone with a major mental illness. So mental health and mental illness factors interact. Putting the two continuums together as quadrants, we see the relationship between them:

The quadrants can be explained as follows:

Quadrant 1: people have good mental health and no mental illness.

Quadrant 2: people may have severe stresses on their mental health but do not have a mental illness.

Quadrant 3: people may have mental illnesses but still have good mental health. With a secure income, strong support from family and friends, a home and a job to return to after episodes of illness, a person may cope well with the challenge of having a mental illness.

Quadrant 4: people have mental illnesses and also severe stress on their mental health. They may be unemployed, living in poverty and poor housing, with little family or social support. They may experience stigma and discrimination and have little access to education and satisfying work opportunities. Quadrant 4 represents the people with the greatest needs for both mental health services and community support.

At 32, Ruth has been depressed for years. In order to leave her chaotic family home, Ruth got married at 16 and had two children by the time the marriage broke up four years later. Suffering from severe depression, she was unable to support her two small children and her ex-husband gained custody. Over the last ten years Ruth has taken computer courses and worked hard to establish a home for her children, despite having repeated episodes of depression. At last things are looking up: she has a full-time job and her daughter, now 15, wants to come and live with her. Suddenly Ruth has started having uncontrollable flashbacks of childhood sexual abuse, which she has shut out of her awareness for many years. Her doctor tells her this is happening because she is now strong enough to handle it, and has given her a new diagnosis of Post Traumatic Stress Disorder. Ruth will need a lot of therapy, support and understanding to deal with her painful memories. Fortunately, the small town where she lives is less than an hour's drive from a centre where services are available.

THE CONCEPT OF RECOVERY

Jill is not just unemployed, she is on the psych ward for the third time since she was 17. She is depressed, suicidal and racked with anxiety and guilt. She was a straight A student but now she can't get her life together, and she calls herself stupid and lazy. Each bi-polar episode has made it more difficult to get back on track. Her family can't accept that she is mentally ill and they've given up on her. Jill is alone and afraid. The hospital social worker has helped her apply for social assistance, but she's depending on a friend she made last time she was in hospital to help her find a place she can afford to live.

Despite tremendous advances in the treatment of major mental illness, there are, at this point in time, no "cures" but as with physical disability, a person with a mental illness can recover and lead a fulfilling life if the necessary supports are available.

Recovery is described by psychiatrist and author, William Anthony, as "a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

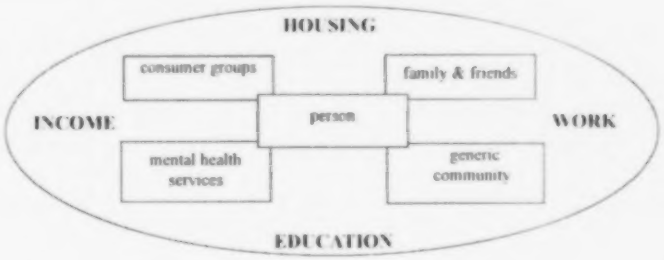
The concept of recovery gives us a new way of seeing the goals of the mental health system. Recovery is about much more than treatment of symptoms: it is about personal growth and well-being, supported by the availability of essential resources and services.

To sum up, **"Apart from illness-related needs, people with mental illness have the same range of mental health needs as anyone else. The process of achieving mental well-being is the same for everyone: it involves removing the barriers that prevent the individual, the group and the community from interacting in positive ways" (Striking a Balance)**[5]

Our vision of a provincial mental health system that promotes well-being is based on this understanding.

THE COMMUNITY RESOURCE BASED MODEL

The Community Resource Base Model provides a framework for supporting the well-being of any person with mental health needs:



The focus of this framework is on the person-in-the-centre, the unique individual with mental health needs, linked to the following resources:

1. Medical/clinical services, both hospital and community-based, are needed to treat mental illness and provide therapeutic interventions that prevent deterioration of individual, family and/or community mental health.

2. Community services such as income support, housing and employment services are crucial to enabling the person to return to life in the community. Both community groups (e.g. churches) and activities (eg. recreation, volunteering, hobbies and entertainment) are all important connections to community life.

3. The informal support given by family and friends is the single most important factor supporting mental well-being. Families provide much of the care, accommodation and financial assistance that enables people with mental illnesses to stay out of hospital, but frequently receive little recognition, information and support from the formal system for the role they play. If a person has no family support, home care services like those provided for people with physical disabilities may be necessary.

Growing up in a small community, Jason was a loner as a teenager and became increasingly withdrawn. He had his first episode of schizophrenia during his second term at University and has been in hospital four times in the last six years. He had to stay in town to maintain his treatment and doctor's visits, and he has scraped by, living in boarding homes and bedsitters on only $603 per month. He attended several programs but was never well enough to get a job. His main support has come from his counsellor and the friends he made through a self-help group. Last year funding was approved for Jason to start on one of the new drugs, and he is feeling much better for the first time in years. He is hoping to go back to University part-time and would like to become a librarian.

4. The consumer self-help movement is an important source of information, education and support for the person with a mental illness or mental health problem. For any experience which puts stress on mental health (from mental illness to divorce, bereavement or care giving), coming together in mutual support groups helps people break out of isolation and share their experience and knowledge with others who have "been there". Studies have shown that participation in self-help increases one's sense of control, strengthens cop ing, and reduces dependence on formal services. Also, some strong advocates have emerged from the self-help movement.

5. The Foundation of the Community Resource Base depicts the elements of citizenship that are essential to participation in mainstream society: income, housing, education and employment (called "Determinants of Health" in Health Canada's population Health Model).Without these elements, people are pushed to the margins of society, with corresponding stress on their mental health.

The Community Resource Base Model has a number of important implications:

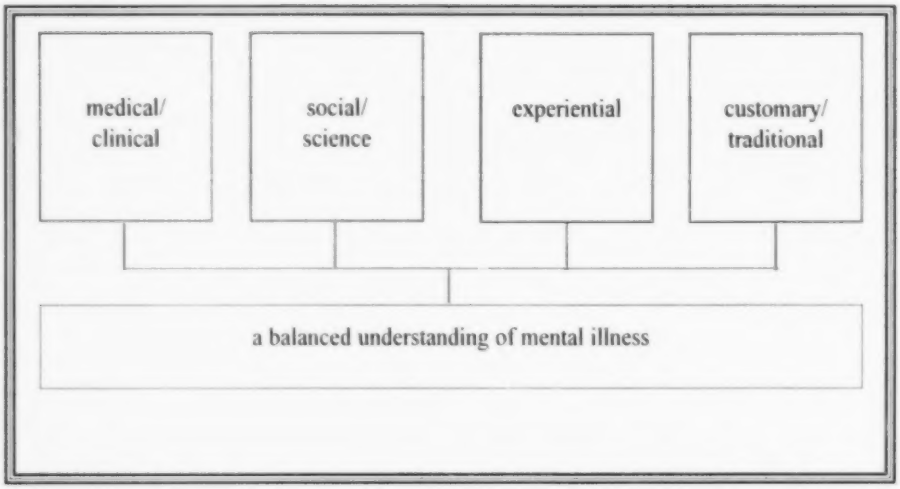
It is person-centered, not system-centered: we need to look through the "lens" of each individual at the range of resources he or she needs, not just to treat mental illness, but to recover and maintain an optimal level of mental health.

It is participatory: the model shows who needs to be part of the team involved in planning and making decisions, particularly the person-in-the-centre and informal caregivers - the people who live with the problem or illness and have their own knowledge and expertise.

It represents a paradigm shift: the model moves beyond the "service paradigm" and the assumption that clinical services alone are responsible for health, while including these as a vital component. Rather, it represents a "community process paradigm." It encourages service providers to see the importance of other community and informal resources and to help develop the natural capacity of people and communities.

THE KNOWLEDGE RESOURCE BASE

To implement the Community Resource Base, we have to value and utilize different kinds of knowledge and expertise, as depicted in the Knowledge Resource Base:[7]



For a balanced understanding of mental illness, we need other kinds of knowledge in addition to that of clinical experts. We need to take account of the social determinants of health such as poverty and environment; we need to learn from the experiential knowledge that comes from the inside, from consumers and family members living with the illness and experiencing its impact on relationships and life in the community; and we need to understand the impact of customary and traditional knowledge e.g. cultural beliefs - fears, myths and stereotypes that feed stigma and make the experience of mental illness particularly difficult. We also have much to learn about non-conventional approaches such as herbal remedies, and the traditional healing practices of our aboriginal people and other cultures.

It was clear from an early age that Matthew was a gifted artist. His parents were devastated when he developed schizo-affective disorder in his late teens, but they were determined that Matthew would have every possible opportunity to realize his potential in spite of this. From early on the family and the clinical team worked together to support him through episodes of illness and recovery. Matthew went back to school part-time and succeeded in completing his Fine Arts degree over a period of nine years. "My two best friends hung in with me, and my folks were always there to back me up," says Matthew. "The school was great too - they let me work at my own pace." Matthew's painting continues to develop, and his work is being displayed and sold in art shows and galleries.

DIRECTIONS FOR THE FUTURE

The last thing Betty wanted to do when she was diagnosed was tell anyone else. A health professional herself, she felt unable to admit she had a mental illness, particularly because of the stigma involved. Betty felt ashamed and isolated. Finally, on the advice of her therapist, she attended a self-help group. "That was the day my life turned around," says Betty. "I met people who knew what it was like because they had been there too. I always thought that going to others for support was a sign of weakness, right? WRONG! I learned that we all need to get support from others, and that it feels great when you can give support out of your own experience. And most of all, I learned that life goes on..."

Vision

Mental health and well-being occur:

- when people live, develop, learn, work, relax and heal in a way that enables them to make choices and participate fully in community life.
- when people have access, as close to home as possible, to a comprehensive, connected range of supports and services focused on the promotion, maintenance and recovery of mental well-being.

Values

We believe that the following values are fundamental to the achievement of good mental health for individuals and communities:

- the right to dignity, respect and choices
- participation in decision-making
- recognition of individual strengths and differences
- individual and collective responsibility
- fairness and social justice

Provincial policy and practice are to be based on these values, in order to support the type of system most effective in promoting mental health.

Principles

The implementation of policy is to be guided by key principles. These principles encourage select activities to achieve the vision:

Person-Centered and Participatory

- responsive to the unique needs of the individual, across all age groups
- individuals and communities define their own needs and participate in the planning and delivery of services

Accessible and User Friendly

- provides good, consistent information about available services and supports
- easy to understand and access

Community-Based

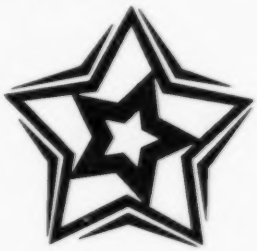
- supports the individual living in the community
- provides the least restrictive form of care as close to home as possible

A Comprehensive Continuum

- provides a continuum of services and supports, including informal supports, focused on well-being and recovery
- encompasses promotion, prevention, crisis intervention, acute and continuing care, case management and support, with an emphasis on prevention and early intervention

Appropriate and Coordinated

- connects the person to the most appropriate service or support
- enables smooth connection to other resources that people need to maintain their mental health



Collaborative

- involves a multi-disciplinary team approach, with the person and significant caregiver included as key members of the team
- respects and supports the caring role of family and friends
- values self-help and other informal initiatives
- uses a range of knowledge bases

Sensitive to Regional and Community Needs

- responsive to regional needs and differences, while maintaining consistency in access to service province-wide
- involves partnerships within communities and generates community capacity and ownership

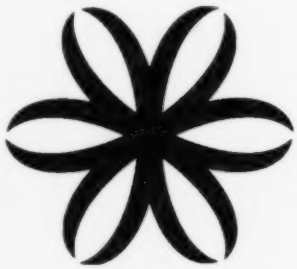
Efficient and Accountable

- uses evidence-based Best Practices for planning, monitoring and evaluation
- uses resources appropriately and efficiently
- is accountable both to the consumer and the public for quality of service

Cautions

As well as guiding principles, there are guiding cautions. We do not want a mental health system which:

- institutionalizes services
- makes service criteria more important than people's needs
- hospitalizes people inappropriately
- has long waiting lists for needed services
- practices tokenism (inviting people to participate but not truly valuing their input)
- uses the medical model of service delivery exclusively
- stigmatizes consumers or their families



Goals

Goals define what we want our mental health policies to accomplish:

1. Through education and information, promote and support the good mental health of all people of Newfoundland and Labrador.

   - ✦ community education about mental health and mental illness, and reduction of stigma related to mental illness
   - ✦ increase people's capacity to lead productive lives within their communities
   - ✦ build on individual and community strengths

2. Provide the professional services needed by individuals with mental illnesses or mental health problems at the time and in the way that is appropriate to their situation.

   - ✦ develop a continuum of care which addresses current gaps
   - ✦ a comprehensive range of services across the age spectrum, gender sensitive
   - ✦ early diagnosis and intervention

3. Ensure smooth connection to the other community services and supports that people need to maintain their mental health.

   - ✦ effective coordination, collaboration and communication
   - ✦ promote teamwork and partnership locally, regionally and province-wide

4. Ensure the involvement of the individual and significant caregivers (family or friends) in planning and decision-making.

   - ✦ meaningful consumer and family participation at all levels
   - ✦ education and resources to support participation

5. Ensure accountability of the system to the consumer and the public

   - ✦ use Best Practices to establish evaluation frameworks

6. Make the most effective, flexible use of available resources

   - ✦ allocate funding and human resources to support vision of comprehensive mental health system

SUPPORTING EVIDENCE

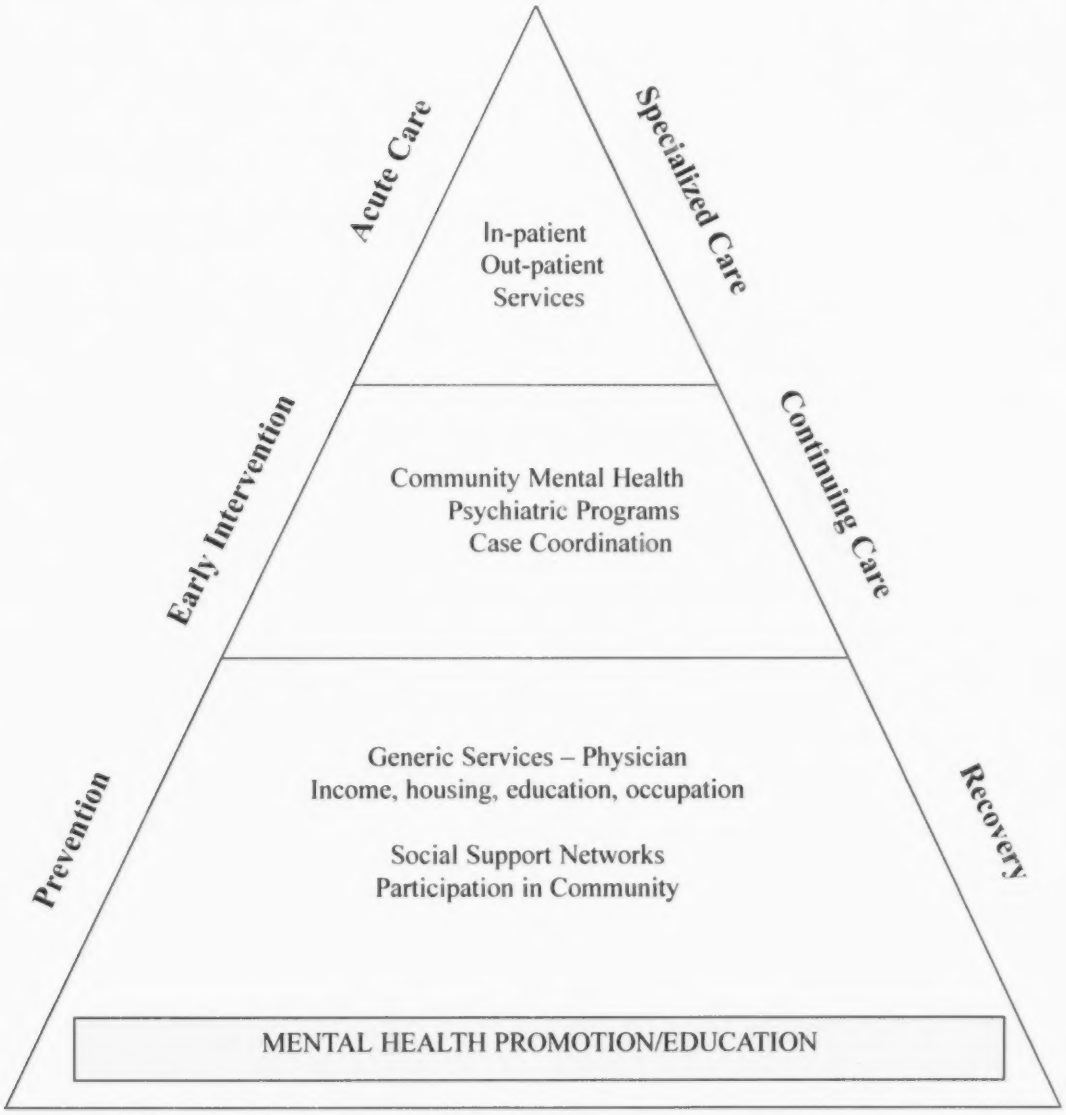
BEST PRACTICE KNOWLEDGE

The development of our mental health system needs to be guided by what is known to work. The following table identifies nationally accepted, evidence-based findings on Best Practices in Mental Health Reform, defining the core elements of a mental health system which supports recovery and well-being.9 We need to learn from these findings and use them to guide goal-setting and the development mental health outcome indicators:

Key Elements of A Reformed System of Care	
Best Practice Area	**Checklist Criteria**
Case Management/ACT	An array of clinical case management programs are in place that follow rehabilitation, personal strengths and Assertive Community Treatment (ACT) models. There is an emphasis on ACT models for those who need intensive support, including special needs groups such as the homeless and persons with dual disorders.
Crisis Response/ Emergency Services	A continuum of crisis programs are in place to help people resolve crises using minimally intrusive options.
Housing	There is a variety of housing alternatives available, ranging from supervised community residences to supported housing, with emphasis on supported housing. Housing needs of the homeless mentally ill are addressed.
Inpatient /outpatient care	Inpatient stays are kept as short as possible without harming patient out comes. An array of treatment alternatives to inpatient hospitalization are available, including day hospitalization and home treatment. Long stay patients in provincial psychiatric hospitals are moved into alternative care models in the community. Service delivery models link family physicians with mental health specialists.
Consumer Initiatives	Consumer initiatives are in place that have diverse purposes such as mutual aid, skills training and economic development. Consumer initiatives are supported through funding, consumer leadership training, education of professionals and the public about consumer initiatives, and evaluation using appropriate methods.
Family self-help	Funding is provided to family groups who also participate in planning and evaluation of care delivery.
Vocational/educational supports	There are supported employment programs in place, and plans for implementing and evaluating pilot programs in supported education and social recreation.

A SERVICE FRAMEWORK

The following diagram shows the different levels of service that are needed to support mental health and well-being, prevent avoidable problems and crises, treat illness and enable recovery:



The **base** of the pyramid represents the broad dimension of mental health and well-being, where people live in the community and cope well with the daily demands of their lives. Social support networks and involvement in work or other activities contribute to the experience of well-being.

Everyone should be entitled to access **generic services** (eg. family physician, housing, education and income support) according to need. These services should be available within the local area.

When significant mental health problems or symptoms of mental illness develop, access is needed as quickly as possible to appropriate community mental health programs. These programs would include crisis response, counselling and community-based psychiatric services (which might be provided by a family physician in consultation with a psychiatrist). Also included would be community-based services such as case-coordination, supported housing and vocational programs, as well as self-help groups and consumer initiatives.

Acute and specialized psychiatric care would be provided primarily in regional centres on an in-patient and out-patient basis. A small number of specialized services may have to provided through provincial programs.

Mental health education and promotion would be needed for all people and should be included as an integral part of all services.

THE CHALLENGES AHEAD

CURRENT STATUS:

Our current mental health services reflect the history of their development. The provincial psychiatric centre in St. John's is a modernized Waterford Hospital with reduced beds and community programs, yet dating from the days when people with serious mental illnesses were detained in large institutions for much of their lives.

Psychiatric units in some general hospitals provide services on a regional level, although people with specialized needs may still have to come to St. John's.

In urban centres, where the bulk of the mental health budget is allocated to the hospital sector, mental health programs serving people living in the community are often hospital-run. A few community programs have been started by voluntary groups to respond to the need for services in the areas of housing, employment, counselling and social support. Since the establishment of regional community health boards in 1994, there has been a small increase in the number of community-based mental health counsellors and mental health programs in rural areas.

Departments of government other than Health and Community Services also serve people with mental illnesses and mental health problems who are in their systems. Justice and Education are significantly involved, while Human Resources and Employment plays a key role for people who need the basic supports of income, housing and medications.

In the private sector, there is a growing number of fee-for-service practitioners. Health insurance policies and employee assistance programs will often assist with part-payment of fees, but many people who need services do not have these benefits.

None of these pieces is part of an overall plan. Different organizations develop their programs separately and resources are allocated on a service-by-service basis. To bring about effective coordination among agencies across the continuum of care, and also between government departments, is a major challenge.

ISSUES TO ADDRESS

While there is broad agreement on the kind of mental health system we want, there are obstacles that we need to address. These derive both from the history of mental health service provision (in which this province is no different from others across Canada) and from the particular challenges posed by our geography, our economy and the changes taking place within our communities. We must find creative ways, at both the provincial and regional levels, to ensure that people throughout the province can obtain appropriate support and services when they need them.

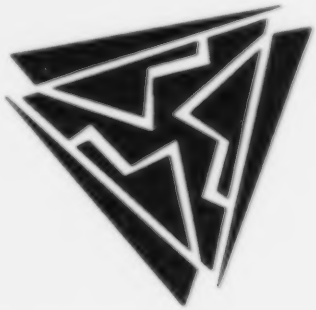
1. Reducing Regional Disparities

While geographic, cultural and other characteristics of the province make differences in service provision inevitable, there are major inequities between regions in terms of access to services. Factors that contribute to these inequities include:

- distance from services
- lack of community supports
- out-migration of younger people
- aging population
- difficulties in recruiting and retaining mental health professionals in rural areas
- centralization of specialized services

Objective:

⇨ each region involve key stakeholders in an analysis of regional service components and gaps according to Best Practices continuum



2. Developing a Genuine Continuum

At present we do not have a solid continuum of mental health care. Even in St. John's, with its relative wealth of services, there are serious gaps, and resources are much less in the other health regions. Some of the problems/challenges that have arisen as a result of these inadequacies include:

- the system has a crisis orientation rather than a prevention or early intervention focus
- there is difficulty in accessing appropriate services
- services are used inappropriately at times
- there is an overuse of police resources for transportation and detention
- individual/family need is sometimes secondary to agency eligibility criteria

Objective:

⇨ each region involve key stakeholders in identifying priorities for services and supports to be accessed at a local and regional level

3. Improving Coordination, Collaboration and Communication

Along with the present fragmentation of services, there is often a lack of mutual understanding between agencies or sectors, especially during this period of major restructuring. It is difficult for hard-pressed service-providers to keep abreast of all relevant developments. This means clients may get inadequate information about what is available to support them, or "get the runaround" of referral to programs for which they do not fit the criteria. Factors that hinder collaboration among components of the service system:

- lack of connectedness/coordination between services
- communication among mental health and other agencies and supports "turf" issues
- poor communication with consumer and family about what is and is not available, including limitations of services
- unclear expectations and corresponding disappointment on the part of the consumer

Objectives:

⇨ The development of a regional plan that facilitates networking and cooperative programming among significant stakeholders

4. Making Better Use of Human Resources

The legacy of the system's focus on treatment rather than prevention/promotion includes:

- ✦ system oriented to medical and hospital-based treatment
- ✦ dependence on psychiatrists for multiple functions, including gate-keeping and referral to other disciplines
- ✦ labour organizations focused on employment in institutions

We need to make better use of our qualified mental health professionals and enable psychiatrists to provide specialized and consulting services, particularly to rural areas and to family physicians. We need to assign more staff to community-based services. We also need to recognize the role played by volunteers and self-help groups in providing emotional support as a form of prevention, as well as an adjunct to counselling and psychotherapy.

Objectives:

- ⇨ appropriate distribution of responsibilities among available mental health professionals
- ⇨ a labour strategy to facilitate staffing community-based services
- ⇨ support for consumer and family self-help group development
- ⇨ community training for people interested in providing help and support to others

5. Becoming Person-Centered and Participatory

When there are gaps and inadequate coordination, it is more likely that the person will have to fit into the system rather than the system being responsive to the needs of the individual. Over the last ten years, the provincial mental health consumer movement has highlighted the importance of individuals taking part in planning and decision-making that affects them, but there continue to be barriers:

- stigma and lack of sensitivity to the experience of mental illness, even within mental health services
- tokenism
- a persisting conviction that "the professional knows best"
- discomfort with and lack of knowledge about how to support genuine participation by consumers

Objectives:

- ⇨ include consumer-presented experiential knowledge in professional curriculums, orientations and inservice training
- ⇨ allocate resources (transportation, meals, day-care, and where appropriate honorariums) to support consumer participation

6. Obstacles to User-friendly Access

At present we have multiple entry points to the mental health system, and the lack of coordination and communication described above often leads to confusion and frustration on the part of the consumer. It is questionable whether a one-stop access system is feasible: all parts of the system need to be points of entry.

Objectives:

- ⇨ clear, accurate, easy to understand information about the range of services and supports available locally, regionally and provincially
- ⇨ help available to explain so that person knows where, what, how to access
- ⇨ support in making connections

7. Fragmented Resource Allocation

Despite what we know about the need for community-based resources to support mental health, at least three quarters of the mental health budget continues to be spent on hospital services. Recent years have seen reductions in institutional beds, but the funds saved have not been reallocated to community programs. Given the limitation of available resources, we need a critical, on-going review of:

- ✦ where and how mental health funding is spent
- ✦ how to make better use of existing formal resources
- ✦ how to maximize the potential of other community and informal resources

We need coordinated budgeting for mental health services to enable resources to be allocated as part of an overall plan and transferred from one area to another according to priorities. The current system of separate budgeting for institutional and community services prohibits this kind of flexibility and makes it very difficult to develop a real continuum of care.

Objectives:

- ⇨ a coordinated approach to mental health budgeting
- ⇨ enhancement of community-based services
- ⇨ use of Best Practices framework for monitoring and evaluation
- ⇨ accountability via social as well as financial auditing

8. Consumer Rights and Mental Health Legislation

The rights and civil liberties of people with mental illness must be guaranteed and protected. The current Mental Health Act dates from 1971 and requires a complete overhaul to bring it in line with human rights legislation, including consent to treatment, appeal procedures and the right to advocacy. Involuntary detention disenfranchises very ill people, and the use of police to bring people for assessment is often traumatic. The right to privacy, dignity and respect must be paramount, and consumers must have access to information on their rights and to advocacy services to ensure their rights. Also to be addressed is the exclusion from the Advance Health Care Directives legislation of people certified under the Mental Health Act.

Objectives:

- ⇨ a new Mental Health Act with provision for Advance Health Care Directives
- ⇨ support of mental health and consumer advocacy within each region

CONCLUSION

To advance the vision of a comprehensive, responsive mental health system to reality, a mental health strategic plan will need to be developed. This will require the involvement and commitment of participants representing the four core elements of the Community Resource Base Model and with mental health consumers providing leadership. Guided by the directions set out in this document, future work will involve provincial, regional and local participants working together to design a plan to resolve the challenges and foster collaboration between all parts of the system in all parts of the province. Key considerations in achieving provincial standards and regional equity will include:

- **accessibility**: What programs and supports are needed at the community level to respond to the everyday needs of individuals and families with mental health concerns? How should specialized services be structured and organized?

- **availability**: What constitutes an adequate range of formal (income support, housing, etc.) and informal supports (volunteers, self-help groups, etc.) within a health region?

- **sustainability**: What is the overall funding for mental health services and how is that funding broken down by region, level of service etc. What are the service priorities?

- **quality**: What outcomes are being achieved through mental health service provision? what is being evaluated within the system?

Efforts to reshape the mental health system are consistent with the overall reform happening within the larger health and community services system. Timing is right to move forward and create the array of services and programs that will have the most impact on the health and well being of the whole population. **VALUING MENTAL HEALTH** provides the beginning framework for a successful transition.

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APPENDIX B

Program Descriptions

Appendix B

PROGRAM DESCRIPTION
1. Acute Primary Mental Health and Addictions Services Includes short term, time limited community based interventions aimed at the prevention or quick resolution of a developing mental health problem or condition. May include: ❑ Screening/identification of individuals/families vulnerable for mental illness and/or addiction. ❑ Assessment, treatment and follow-up of individuals with mental illness and/or addiction. ❑ Involvement in shared-care arrangements and consultative processes. ❑ Implementation of targeted interventions, including community workshops and group sessions. ❑ Partnering with local groups regarding early intervention strategies. ❑ Monitoring of key indicators of the mental health status of the population. ❑ Collaboration on the development and implementation of provincial programs and materials related to prevention initiatives. ❑ Involvement in program effectiveness efforts.
2. Case Management Refers to a clinical approach for individuals with serious mental illness and/or chronic addictions that involves the coordination of care and treatment and other living supports required for recovery. ❑ Roles may also include responsibility for supportive counseling, home visits, consumer and family education, facilitating relationships and effective connections among various members of the community 'team' and other client-specific interventions such as medication monitoring. ❑ Case management is longer term and ongoing and can complement other services such as mobile crisis response and home support. ❑ It is an important role designed to alleviate the fragmentation that can occur between different levels of the system.

PROGRAM DESCRIPTION

3. Emergency services/crisis response

A range of services focused on providing timely, coordinated responses for people of all ages experiencing a mental health crisis that requires immediate intervention.

- ❑ Response will be accessible (within 60 minutes by car) for 90 percent of the population and available 24 hours a day, seven days a week, 365 days a year.
- ❑ A mobile response will be developed regionally to address diverse needs of all age groups and varying complexities, including a person in drug withdrawal, a suicidal teen, an adult experiencing psychosis, or a senior suffering from dementia.
- ❑ Police intervention in mobile response will be limited to situations with predetermined criteria such as barricading, weapons or hostage takings. Crisis response is a mental health service and will be coordinated by health staff. Regions will determine whether the response includes ambulance, mental health/addictions staff or a combination of both.
- ❑ On-call crisis workers affiliated with the Janeway Child Health Program, will be available to provide direct intervention for children and youth within the Eastern Regional Integrated Health Authority and consultation to other regions.
- ❑ The use of lock-ups to detain individuals under the *Mental Health Act* will be eliminated except in extreme circumstances.
- ❑ Protocols, based on best practices, will be developed, including standards for continuing education and support for crisis responders.
- ❑ A 24-hour crisis line will continue as part of the array of emergency services. The line must have the capacity to be accessed by all age groups and levels of ability including persons who are hearing impaired.
- ❑ Each region will have access to designated crisis beds, either based in hospital or in the community.

4. Consultation and Shared Care

Consultation and shared-care are critical components for service delivery within the geographic realities of the province. Advances in technology allow timely and ongoing consultation that is essential for the provision of high quality mental health care at all levels of the system.

- ❑ Selected mental health and addictions professionals who have specialized knowledge will be identified and supported as regional consultants in their area of expertise.
- ❑ Consistent policies, at both the regional and provincial level, will be adopted that support consultation as a valued and essential role of mental health professionals.
- ❑ Psychiatrists, mental health clinicians, addictions workers and family physicians will be encouraged to develop shared care arrangements that clearly identify roles and responsibilities and how best to support each other in providing primary mental health care.
- ❑ Psychiatrists will implement a variety of ways to provide consultation throughout all regions such as traveling clinics and videoconferencing.
- ❑ Issues of remuneration will need to be clarified for fee for service physicians who participate in consultation and shared care arrangements. For other mental health professionals, workloads and job responsibilities will reflect the need for consultation.

5. Home and Community Support

Involves a continuum of activities, services and supports that provide assistance to consumers and their families to live quality lives in their communities. The type and range of supports available will vary by region but may include:

- ❑ housing supports;
- ❑ transportation services;
- ❑ life skills and self-help programs;
- ❑ family supports such as respite, caregiver and parenting programs.

APPENDIX C

Report of the Expert Think Tanks (April 2004)

WORKING TOGETHER FOR MENTAL HEALTH

Developing a Mental Health and Addictions Policy Framework for Newfoundland and Labrador

FINDINGS FROM THE FOUR EXPERT THINK TANK SESSIONS

Submitted by: Ellen Oliver, MSW, RSW
April 6, 2004

Submitted to: The Mental Health Team
Department of Health and Community Services

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DESCRIPTION OF THE THINK TANK PROCESS

The purpose of the think tanks was to ensure the most comprehensive and responsive mental health strategy in the areas of child and youth mental health; seniors mental health; addictions; and specialized mental health/addictions services. People from across the province with particular areas of expertise came together as follows: Children and Youth on March 1, Seniors on March 3, and People with Addictions on March 8. A separate session addressed specialized service across all populations and this was held on March 11 and 12. Three of the meetings were held in St. John's and one occurred in Corner Brook. The sessions were planned and facilitated by members of the mental health strategy team and a consultant from the School of Social Work.

Participants in each session represented various areas of service provision, consumer organizations, community agencies that are partners in the provision of mental health services, consumers and government departments. For a complete list of participants, please see Appendix A.

Each session began with a brief presentation from the strategy team coordinator who outlined the background of the strategy and the anticipated outcomes from the think tanks. Several invited presenters then gave brief commentaries on current issues and trends. A consultant psychiatrist was present for the session on specialized services and provided information and analysis at various points during the meeting. The facilitator offered an overview of the agenda each day and engaged the group in discussion that assisted in focusing their thinking on the matters to be addressed during the day.

The majority of each day was spent in small groups where participants discussed their views on how a service system should be designed. They engaged in fairly detailed discussions that resulted in descriptions of a variety of service components. The groups attempted to outline the types of systems that would be best suited to rural and urban areas and they deliberated about responsibilities that belong with families, community organizations, volunteer organizations, regional health and community services, the provincial Department of Health and Community Services and other government departments. This discussion resulted in the gathering of a great diversity of ideas and many very specific recommendations for the design of a comprehensive mental health system.

The major themes that emerged from the sessions are outlined in the first section of this report. These are organized under the categories of: service components; education / training; coordination; policy development; partnerships/community involvement and funding/resources. The description of general themes is followed by an overview of the issues and recommendations related to each population that was addressed during the think tanks. The final sections of this report offer a proposed model for service delivery and a brief conclusion.

THEMES IDENTIFIED ACROSS ALL SERVICE AREAS/POPULATIONS

Service Components:

Primary Prevention:

There was general agreement that the responsibility for primary prevention initiatives is shared among primary health care providers, mental health service providers, community organizations and volunteer organizations. However, it was acknowledged that often a responsibility that is widely shared becomes lost and nobody actually takes responsibility to implement specific activities.

Recommendation: Primary mental health prevention should be coordinated within primary health care teams, by mental health/addictions staff who have it as their primary role.

Participants recognized that there are sources of information that can assist with creating a primary prevention program for various target groups. Such resources include the Community Accounts System and best practices literature. The actual content of messages and interventions may be similar in all regions although the methods of delivery would vary across regions.

Recommendation: The provincial Department of Health and Community Services' wellness initiative accept a leadership role in developing primary mental health prevention materials and that these be made available to regions for delivery.

Consultation:

The availability of consultation was identified as a key component for a strategy that must address the geographic realities of this province. Everyone noted that it is highly unlikely that each local area will ever contain all the expertise that is needed to adequately address the issues of people with mental health problems, addictions issues and mental illness. There will always be a need to rely on consultation from experts who may reside many miles away from the person who must deliver the service. Timely and ongoing consultation is essential to all aspects of the service system. At present, the role of consultant is one that professionals perform when they can manage to free up a few minutes or hours. This role is usually not acknowledged in their workload or in their compensation.

Recommendation: The health system, at both the regional and provincial level, adopt consistent policies that support the role of consultation as a valued and essential aspect of the role of mental health professionals. These policies need to address consultations across agency boundaries as well as principles of shared care.

Recommendation: Selected mental health professionals who have specialized knowledge be identified as regional consultants in their area of expertise. Their workloads and job descriptions be modified to reflect this responsibility.

Crisis Intervention and Stabilization:

The need for a response to crisis outside of the regular workday was highlighted as an urgent need for all populations. Participants emphasized that a crisis response system must be sufficiently flexible to address the diverse needs of all age groups and varying complexities of crisis situations. Responders may be required to address such situations as: a mentally ill person who is actively psychotic, a person who is coping poorly and acting in an aggressive manner, an out of control teen, an elderly person suffering from dementia who is unmanageable in the home and an adult who is experiencing detoxification at home.

Recommendation: Establish a 24-hour crisis line that is accessible in all regions and is publicly advertised as a resource. The line must have the capacity to be accessed by all age groups and levels of ability including people who are hearing impaired/deaf and young children.

Recommendation: Establish mobile crisis response in all regions of the province. This response would be designed to fit the particular geographic and resource realities of the region. The teams may include assistance from police in select instances.

Recommendation: Beds for crisis stabilization should be available in each region and be located in a safe and secure area. These beds may be situated in the community or in institutional settings. The areas where the beds are located should be especially designed to ensure safety. The staff who are assigned to these areas must have training that equips them to provide stabilization interventions.

Acute Care:

There was emphasis on the need to expand the acute care system of services and ensure that it is not dependent only on the availability of acute care beds. Participants acknowledged the need for acute care admissions and agreed such admissions should occur at secondary level facilities. There was significant importance placed on community based acute care services. A number of such services currently exist but not all regions have reasonable access and not all existing services are appropriately utilized.

Recommendation: Acute care beds should be available in all regions. These beds may be on psychiatric units but might also be flex beds or designated beds within medical units and long term care facilities. The presence of these beds would also require the presence of properly trained staff.

Recommendation: Each region should have a day hospital in an area of the region where such a service is feasible.

Assessment, Counseling and Therapy:

Participants maintained that the major focus for resource deployment and development should occur at the community level. Most people with mental health problems, mental illness and addictions live with their problems in community settings and with few exceptions, it is within the communities that the main treatment and support initiatives should occur. The counseling needs in any community will be diverse and in rural areas there will be small numbers of people who need any particular type of service. The range of counseling services needed include: grief/loss counseling, caregiver support, family therapy, symptom management intervention, addictions counseling, behavior management interventions, group therapy and psycho-educational counseling. There was encouragement to think broadly about the resources that could be more closely linked to a comprehensive mental health strategy and to maximize the effectiveness of resources by creative and efficient planning and implementation of services.

Recommendation: Create interdisciplinary teams in each region. Team members should be competent to provide generalist services as well as assume selected specialist functions.

Recommendation: Implement a provincial standardized assessment process that addresses mental health, addictions and mental illness.

Recommendation: Each region should establish community programming at various sites that provide support and respite services to all populations.

Specialized Services:

A number of services were seen as being best delivered from St. John's where the majority of such services are already located. However, there was acceptance of an enhanced role for regions in relation to delivery of selected specialized services. The ideal goal for regions is self-sufficiency but the reality of the distribution of the population of the province dictates that certain services will remain centralized for the foreseeable future.

Mental health services for our province should be organized to ensure that individuals receive the level of care they require. Tertiary care should not be identified with a building, such as Waterford, but rather be separated from location of care in order to

create effective, efficient and responsive mental health services. As with other psychiatric hospitals across the continent and around the world, Waterford has been downsized over the past several decades and this downsizing needs to continue. Primary mental health services should be community based and secondary services should be community based or at least located within general hospital settings.

Recommendation: Tertiary care programs should include services for:

1. *Children and youth*
2. *Seniors*
3. *Those with acquired brain injuries or neuropsychiatric disorders*
4. *Those with concurrent disorders (mental illness and an addiction)*
5. *Those with a dual diagnosis (mental illness and developmental disability)*
6. *Those requiring forensic services*

Recommendation: The roles of tertiary care centers, specifically the Waterford and the Janeway, be clarified and modified to more adequately address provincial needs for expert assessment and intervention.

Education/Training

The acceptance of the need for more regional self-sufficiency in relation to all service components led to questions about the competence of existing staff in relation to mental health services. There is a willingness to broaden responsibility for services and to develop more specialized services at the regional level. However, these developments can only occur with increased training for existing staff. Increased training could assist with initiatives such as: long term care staff providing on-site mental health services for people who now must be transferred to other facilities, and staff on pediatric units more readily addressing needs of children and youth.

Recommendation: The provincial Department of Health and Community Services approach the university to request increased mental health content and specialized training for professionals who will likely provide services in the field of mental health.

Recommendation: Implement a continuing education program that addresses the additional training needs of staff who will be expanding their role in the delivery of mental health services. The training should include generalist skills and specialized treatment competencies.

Recommendation: Regional boards support staff in attending regular meetings with colleagues to: share knowledge; increase competencies through case discussion, review and discussion of research and best practices literature and further develop expertise in specified specialist functions.

It was acknowledged that family members and other care givers often provide the ongoing support that is required to maintain individuals in their own homes and/or community settings. These people often have little or no access to information and training that could greatly assist their care efforts. Information sessions on caregiver stress, information packages on at-home detoxification and training in the ISSP coordination model were a few of the suggested areas in which education should be available to caregivers.

Recommendation: Regional health organizations develop education programs for caregivers and clients to increase their ability to be self-advocates and support the care giving that occurs by the family and community.

Coordination

There are varying levels of service availability throughout the province but there is no one source where information about these services can be obtained. The regionalization of services removed any provincial coordination and knowledge of services and while people within a region may know about most services in the region, they do not always know what might be available outside their region. Consumers also express frustration about the difficulties related to discovering services. They often must seek information from a variety of sources at a time when they are highly stressed and least able to navigate through the complexities of systems.

Recommendation: Create a coordinator position that represents an access point for information and linking with mental health services and services that support people with mental health problems, addictions and mental illness. This position should have provincial scope. It should be supported by computerized information systems and a web site. The person in this position should be accessible by consumers and professionals at a toll free number. It should be located in a non-profit organization that is currently connected to mental health.

Recommendation: The provincial government create a secretariat or at a minimum a mental health consultant who can be responsible for the ongoing development and monitoring of the mental health service system.

Recommendation: Opportunities be created on a regular basis for management and staff in mental health/addictions to meet to discuss matters related to coordination of services and program development. These should occur on a regional and provincial level.

Policy Development

The absence of modern legislation related to mental health and neglected adults continues to be a source of concern for those who provide services and for consumers and their families. It is felt that the current legislation does not offer direction that reflects accepted mental health practices and developments related to the rights of consumers.

Recommendation: The provincial government prepare and enact a new Mental Health Act and a new Neglected Adults Act.

A major impediment to the effective and efficient delivery of service and the appropriate use of services is the lack of cohesiveness among policies across government departments. Participants cited examples of services that are virtually inaccessible to clients because they lack the financial ability to travel to the service. Policies in the Department of Human Resources, Labor and Employment also do not facilitate their access to appropriate financial support. Policies within this department that restrict the availability of drug cards also dissuade mental health consumers from obtaining employment that while worthwhile from the perspective of promoting mental health is inadequate to support the often high cost of medications. Concerns were also voiced about levels of poverty and inadequate housing that detract from any gains that people make through treatment and support programs.

Recommendation: Government departments review policies that have implications for mental health services and make the modifications that are required to develop interdepartmental support of mental health programs at a policy level.

Although many organizations maintain that they are consumer focused and client driven, there are many examples of planning occurring without the active involvement of consumers and their families. Meaningful involvement of consumers/families must occur in all areas and this is only likely to happen when this expectation is enshrined in policy.

Recommendation: The policies of mental health service organizations include requirements that consumers/families be considered part of the care team.

Partnerships/Community Involvement

A comprehensive mental health strategy must reflect meaningful involvement of consumers, their families and support systems, the formal mental health system, community organizations, related government departments and the volunteer sector. Initiatives that prevent and respond to mental health/addictions problems are a shared responsibility. A reliance on the mental system without support of relevant partners is seen as a poor plan that will lead to an unsustainable and ineffective system. A strong system will exist when there are clear and purposeful partnerships that respect the contributions of consumers and all aspects of communities in which they live.

Recommendation: Ensure that alternate and specialized education programs are available for children and youth with mental health problems.

Recommendation: Increase the capacity of non-profit organizations to properly fulfill their mandate in mental health related areas by increasing their financial support.

Recommendation: Support organizations that have successfully created supportive and subsidized housing to further develop housing options for people who are served through the mental health system.

Recommendation: Emphasize the importance of self-help/mutual aid in all aspects of the mental health service system and particularly in the inventory of services that is promoted on the crisis line.

Funding/Resources

One of the implications of a provincial mental health strategy that improves the quality and availability of services is the need for additional funding and personnel. The participants acknowledged that certain changes could occur by redeploying existing funding and staff. However, regional acceptance of additional responsibilities and the implementation of improved coordination and consultation capacities require additional people and funding. The exact requirements for each region can only be determined as each region develops an implementation plan. These plans will result in an assessment of the possibilities for realignment of personnel and money as well as an identification of new resources that are needed. However, there are several areas of development that cross regional boundaries and which will require additional resources.

Recommendation: Provide funding for a new provincial continuing education program and the required resources identified in approved regional implementation plans.

ISSUES AND RECOMMENDATIONS FOR SPECIFIC PROGRAM AREAS/POPULATIONS

The above material illustrates that there are many issues and strategies that are common to all areas of mental health service delivery. However, it was acknowledged that there are characteristics of populations that generate issues specific to that population and require solutions that are designed to fit the particular characteristics of the population. The regional differences that influence service delivery were also considered by participants and these are referenced at various points in the report. A noteworthy gap in this regard is the absence of any special consideration for services in Labrador. Participants acknowledged that service delivery in Labrador presents unique challenges and the think tanks did not have the representation to address these issues.

This section of the report outlines the recommended ways in which the provincial mental health strategy should address the needs of children and youth, seniors, and people with addictions issues. The service components that will be addressed here are only those that include issues/recommendations that are not reflected in the earlier section of this report.

Children and Youth

Primary Prevention:

It was noted that there are a variety of current health promotion activities that contribute to mental health of children and youth. As well, early intervention programs offer important interventions to at-risk populations. However, the focus on prevention of mental health problems needs strengthening.

Participants determined that the populations that should be targeted for primary prevention approaches include:

- Children of parents with mental health issues addictions;
- Children of socially disadvantaged circumstances;
- Children in care and those on child protection case loads;
- Families in need of parenting role models.

The priorities for intervention at this level should be the following:

- Children/youth of parents with mental illness;
- Families at risk for poor parenting
- Children/youth at high risk for anxiety and/or coping problems.

It was noted that the problems that are most likely to be influenced by primary mental health prevention are suicide ideation, alcohol addiction and eating disorders.

The identification of the risk populations that are outlined above can occur through cooperative efforts among the mental health system, the school system and other divisions of health and community services such as children's protective services.

Recommendation: Accompany implementation of prevention strategies with: policies that support the involvement of families; scheduling of interventions that support family involvement; support for transportation; child and youth centered programming; technological support for remote locations and community level delivery.

Crisis Intervention:

The challenge of crisis intervention was seen to be particularly difficult in centers where there are few properly trained staff and where in-patient beds are unavailable for stabilization of those children/youth who cannot be managed in the community. There was recognition of the fact that each region will have to implement measures that are reasonable within the region but that certain program elements should exist in all services.

The existence of a provincial crisis line and trained staff are necessary to enable the creation of a crisis intervention program. The ability of the Janeway and child psychiatrists to provide consultation is also an essential piece of an effective system.

Recommendation (as referenced earlier on page 3): Establish mobile crisis response in all regions of the province. This response would be designed to fit the particular geographic and resource realities of the region. The response may include assistance from police in select instances.

Recommendation: Provide on-call crisis workers who are affiliated with the Janeway. These workers should provide intervention to the St. John's region and consultation to other regions of the province.

Acute Care:

An effective acute care system for children should consider all areas of the child's life that impact on mental health. Services that are specifically designed to provide mental health services must be linked with a range of services that can support a child through an acute episode of illness and/or a time when mental health issues dominate functioning.

It should be possible to access such services within the region in which they live. Services can be available in community based and/or institutional settings.

Recommendation: A full range of acute care services be developed to include:

- *day programming for children/youth with mental illness;*
- *flexible school programs;*
- *programs for parents of ill children/youth;*
- *dedicated beds for older adolescents be created within existing bed compliment.*
- *involvement of community based mental health teams;*
- *use of technology;*
- *coordination mechanisms such as ISSP*

Community Based Assessment, Counselling and Treatment:

The need for community-based services was strongly supported. There was agreement that the emphasis on community services should increase and that services should be designed to meet the diverse needs of the geographical realities of the province.

Recommendation: Strengthen service components for delivery at the community level including:

- *assessment and referral;*
- *counselling/therapy;*
- *family support;*
- *educational support/alternate education programs.*

The above services require support that make them accessible to people and are culturally sensitive.

Recommendation: Services that focus on 16-19 year olds be given high priority for development since there is an urgent need for service options for this age group.

Family Support Services:

The need for involvement of families that was highlighted in all think tanks was particularly emphasized in relation to services to children and youth. It was felt that families are key as supports to the children/youth who are identified clients. There was also acknowledgement of the fact that families may also be the focus of intervention.

Recommendation: Implement support services for families including:

- *support groups facilitated by professionals;*
- *self-help support groups;*
- *education/information sessions;*
- *respite/practical support.*

Home Based and Outreach Services:

Children and youth who require mental health services often have need for support and assistance in many areas of their life. An effective system was seen to be one in which the needs of the whole person are addressed. The approach to address such needs requires home based and outreach services.

Recommendation: Develop a service system that includes:

- *community recreation programs;*
- *an intake point that is designed to avoid "systems gridlock";*
- *preventive education by mental health professionals;*
- *communications systems that enable various service providers to access information;*
- *coordinated plan of care at all levels;*
- *mental health clinician to communicate between specialized services, schools and families.*

The above services are meant to be delivered in the context of an environment that facilitates client participation. A supportive environment would provide assistance with transportation to services, offer support to single parents and contain family resource centers.

Participants acknowledged the importance of clarifying the difference between mental health issues and behavioral issues and the need to have this difference reflected in the ways that services are offered.

Residential Services:

The need for thorough assessments in relation to residential options was emphasized as a key element in a residential service system. The discussion also referenced the fact that work has been ongoing in this area. A specific initiative titled "Residential Treatment and Beyond: Towards a New Model of Service Delivery for Children, Youth and Families with Complex Needs" was identified as having relevance to the mental health strategy.

Recommendation: Develop a range of residential services including:

- *supportive living arrangements;*
- *residential treatment centers for particular populations;*
- *supportive housing for youth with mental illness;*
- *therapeutic foster care arrangements for younger children who cannot be maintained in their own families;*
- *addictions services that are designed specifically for youth at Humberwood.*

Specialized Services:

The services for this population can be most effectively delivered at the community level. However, there are situations that will require hospitalization and/or residential services.

Recommendation: Develop regional specialized services that include: a team that has members who have specialized training, secure sections on pediatric units, regional emergency shelters, consulting psychiatrists and flex beds on mental health units for the older adolescent.

The Janeway is recognized as the service that will respond primarily to two populations: children and youth with mental illness who are not responding to the regional specialized services and those who present in emergency in crisis. Concerns were expressed that many regions encounter significant difficulties with accessing the services of the Janeway.

Recommendation: Review the role of the Janeway in relation to tertiary services for the regions and improve the response of that facility to the regional needs.

Seniors

Prevention:

The identification of at-risk seniors will usually occur through the efforts of primary health care practitioners. Continuing care social workers as well as church personnel and community organizations are also able to identify seniors who could benefit from preventative intervention.

The populations that were identified as being the focus of prevention efforts include the following:

- older women;
- seniors who live alone
- those who have suffered multiple losses;
- people with major physical illness;
- those with disabilities;
- seniors living in inadequate housing and/or in poverty.

Recommendation: The emphasis in preventative work should be on activities that promote social participation, self-help and mutual aid options and community development that aims to involve groups and organizations in preventative initiatives.

Acute Care Services:

The types of acute care services that are required within the province will vary according to regional needs. The think tank participants considered the composition of such services in two regions of the province and the results of their deliberations are outlined below.

Acute Care in Central Region:

The region should provide services through a collaborative effort that involves Health and Community Services Central, CEPCC and CWHCC. These organizations also need partnerships with relevant services such as the geriatric assessment service in St. John's, consumer organizations and long-term care facilities.

Recommendation: Long term care facilities in the Central Region should dedicate mental health beds and trained staff to provide care for behaviorally and psychologically disordered individuals. The acute care psychiatry beds in Grand Falls can be accessed when the level of care is beyond the scope of the long-term care facility.

Recommendation: Day hospital space should be available as an alternative to acute care hospitalization in a location that is determined appropriate within the region.

This service can be accessed through primary mental health care services, health and community services, general practitioners and long term care facilities. The day hospital must be supported by hostel arrangements and a transportation system. The service requires a multi-disciplinary team and access to neuropsychology and physiotherapy.

The Central Region's ability to manage the acute care needs of seniors could be strengthened by strong links with Memorial University, School of Medicine. The appointment of a faculty member from the Central Region and the introduction of academic teaching rounds would increase resident/clerk positions and thus enhance the treatment capacity of the region.

Recommendation: A formal link be established between the Central Region and Memorial University, School of Medicine.

Acute Care, St. John's Region

It was noted that general hospitals need to increase their capacity to address the needs of seniors with functional disorders and complex medical problems. Additional resources/services are also needed to more adequately address acute mental health needs of seniors.

St. John's currently has acute care capacity at the Waterford Hospital.

Recommendation: The 18 bed geriatric assessment unit needs to separate out two populations, those people with dementia and those with acute mental illness. Nine beds should be allocated to each population. These beds should be relocated outside of the Waterford Hospital.

The geriatric assessment unit is in need of a full complement of services that include:

- neuropsychology;
- internist and other medical services;
- neurology services;
- specific environmental changes;
- increased number of registered nurses;
- licensed practical nurses with psychiatric and gerontology expertise;
- a social work position that is shared with Health and Community Services;
- programs delivered by volunteers;
- structured programs for fitness, reminiscence therapy, music therapy, art therapy and pastoral care.

The services should consider the needs of families and actively involve family members in planning. Support services for families are also required as is connection with community groups such as the Seniors Resource Center and the Alzheimer's Society.

Recommendation: A day hospital program should continue in the St. John's region. This program needs links to community services, long-term care and emergency services. A multi-disciplinary team is required to staff the program.

Recommendation: Establish additional Day Programs that provide supportive services in the St. John's area.

Recommendation: Establish two units as mental health units within Long Term Care facilities. St. Patrick's Mercy Home and the Agnes Pratt Home would be appropriate locations for these units.

A number of initiatives were identified related to improving the response to mental health issues among seniors in long term care facilities. The suggestions here were wide ranging and included the following: training general practitioners in mental health service provision, increasing the standards for the type of staff who provide services (more professional staff), improving support to employees in long term care, providing shorter shifts for staff, increasing emphasis on placing the needs of residents before the needs of unionized employees, increasing visits of psychiatrists to long term care facilities and updating nursing home practice models.

Home Based and Outreach Services:

A goal that is consistent with the wishes of seniors and with best practices is the maintenance of seniors outside of institutions. This goal, although desired, has not been properly supported by the methods of funding and service designs that define our systems of care. There was a clear message from participants that major improvements are needed in this area.

Recommendation: Develop and/or strengthen services that will allow seniors to live outside institutions and experience a good quality of life. The services that are needed to achieve these aims are as follows:

- *supported housing options;*
- *home care that is not dependent on the presence of physical problems;*
- *respite services;*
- *bereavement counseling;*
- *support groups/caregiver networks;*
- *home maintenance;*
- *day programs;*
- *home based case conferencing;*
- *increased use of nurse practitioners;*
- *enhanced role of pharmacist as members of the primary health team;*
- *improved training for home care providers;*
- *addictions counselors who specialize in seniors issues;*
- *social workers in outpatient departments.*

Family Support Services:

Although the home based services that are outlined above are supportive of families, the participants indicated the importance of giving special attention to the needs of families. It was noted that families accept a significant responsibility when they care for a senior at home. This willingness to take responsibility is a key contribution to the maintenance of health in seniors and to relieving stress on an overburdened health system.

Recommendation: Improve family support by considering the issues and services below:

- *assessment that distinguishes family needs from client needs;*
- *a variety of respite options that provide peace of mind;*
- *individual care for caregivers;*
- *time off for families;*
- *subsidized services;*
- *consistency in support relationships;*
- *attention to poverty issues;*
- *use of community volunteers.*

Specialized Seniors Services:

Regions need to have access to specialized medium and long stay beds, some of which may exist in the region while others will be in the Waterford Hospital. Rural and remote communities should be able to access specialized assessment and intervention without moving seniors out of the region.

Recommendation: Provide specialized services in regions by:

- *dividing the region for traveling clinics that occur in primary health centers as well as long term care facilities;*
- *introducing telehealth services that are linked to the traveling clinics;*
- *creating multi-disciplinary regional teams.*

The St. John's Region has specialized services that need improvements. It seems appropriate that services be delivered through the Health Care Corporation of St. John's as well as the St. John's Nursing Home Board.

Recommendation: Two geriatric long term units are currently located at Waterford. These units should have the following as standards for care in order to provide specialized tertiary care: A full inter-disciplinary team should be available which should include at least one psychiatrist for every 25 beds. The team should be able to provide intense recreation therapy and structured therapy and rehabilitation programs. Families and volunteers should form part of the team.

Integrated Mental Health and Addictions Services

It was acknowledged that there are advantages to implementing an integrated mental health and addictions program. An integrated service is one in which service provision is facilitated by various collaborative and coordinating arrangements within and across sectors of the service system.

There is unreserved support for creation of strong linkages among service providers and between community based and in-patient/residential services. There is also an interest in strengthening the connection between formal and informal support systems and recognizing both the role and the needs of families in relation to addictions issues.

Recommendation: Create an integrated system with the following characteristics:

- *centralized service information;*
- *centralized intake and referral;*
- *common assessment and instruments;*
- *use of integrated client record;*
- *system-wide use of bes' practice treatment protocols and programs;*
- *interagency service del. ery teams.*

There are concerns associated with an integrated service system and these are related to the possible loss of specialized knowledge and dilution of specialized treatment. It is very clear that service integration will only be supported if there are built-in mechanisms to preserve specialized knowledge and skills and treatment approaches.

Participants outlined a number of initiatives that are identified as essential to preserving the specialized focus that is viewed as essential for competent service.

Recommendation: Preserve the specialized focus in addictions work through:

- *provincial standards regarding education/training that require: orientation of new staff, established core competencies and shared responsibility for continuing education;*
- *a certification process for addictions counselors;*
- *compensation for specialized training;*
- *consultation among service providers.*

Prevention:

It was noted that the addictions field has traditionally been very active in the area of preventive interventions. There is available literature that outlines best practices in this area and a prevention service should be modeled on this best practice material.

The focus of preventative work should be guided by information about prevalence of various addictions in this province. This information should be obtained from a provincial prevalence study.

Recommendation: Conduct a provincial prevalence study on gambling.

Crisis Intervention and Stabilization:

The crises that might present within the addictions field range from coping problems to medical emergencies. The response system needs to be sufficiently flexible to respond to meet diverse needs.

Recommendation: Develop a crisis response system that is characterized by the following:

- *responders that have the ability to travel to the crisis*
- *limited involvement of police*
- *coordination with other relevant program areas*
- *trained paramedics as first on the scene*
- *informal support systems that receive adequate support*
- *advanced telephone-counselling skills for crisis line staff*

Detoxification:

A full range of withdrawal management services is required and these should be based on thorough assessment. The recommended services are described below.

Home Detoxification

The practice of home detoxification is very common and is often accomplished with minimal support from health professionals. Volunteer support groups and self-help/mutual aid organizations already play a key role in this area.

Recommendation: Establish a safe and effective home detoxification program that is characterized by:

- *workers in all regions who have expertise in detoxification;*
- *recognition of the fact that AA and Al-Anon can provide support;*
- *home support needed for family and children;*
- *facilitated link to family physician;*
- *working partnerships with informal support networks;*
- *partnerships between formal and voluntary sectors;*
- *guidelines for home detoxification possible in a "Detoxification Kit" that could be distributed with cooperation from AA and Al-Anon;*
- *information kit for schools.*

Residential/Medical Based Detoxification

This option is needed particularly for opiate addiction.

Recommendation: Both the Recovery Centre and Humberwood should have medical detoxification capacity.

There was also a suggestion for Humberwood to develop at least a non-medical detoxification program.

There was considerable discussion on the special needs of adolescents and there was a conclusion that adolescents are best served by programs that are especially designed to meet their needs.

Recommendation: Develop day treatment programs in St. John's and Corner Brook and community-based centres in smaller localities that properly address the needs of adolescents with addictions.

Community Based Assessment/Counselling and Therapy:

The consideration of community based services led participants to consider the importance of strong links among the hospital system, community service system, consumer organizations and families of consumers. These links need to be translated into procedures that support the involvement of consumer organizations and community programs during hospital and the appropriate transfer of information and resources across agency boundaries.

Recommendation: Assessment and treatment approaches include the qualities described below:

- *improved screening and referral in emergency;*
- *intake coordination;*
- *contact made with referred client within 48 hours;*
- *need to keep specialized providers;*
- *common screening tool used by all generalists mental health and addictions staff at all points of entry (PHC, community or hospital);*
- *community-based counselling that includes family (joint or separate);*
- *group work interventions;*
- *non-medical residential treatment programs;*
- *day programs with transportation systems;*
- *policies and procedures that highlight the expectation of involvement of families.*

It was noted that family involvement and services to families are sometimes influenced by confidentiality rules and client choice regarding family involvement. All agreed that the systems should have mechanisms to address family needs for service.

Specialized Services:

The previous sections of this report addressed how specialized services could be delivered to children/youth, people with addiction issues and seniors. This section will concern itself with those specialized service areas that are common to more than one population.

Forensic:

There is presently a unit at the Waterford Hospital where forensic assessments occur and patients who are not criminally responsible are offered services. This unit is staffed by a multi-disciplinary team and is the only forensic service in the province.

Recommendation: The forensic unit at the Waterford Hospital should continue to exist with additional psychiatric support and increased linkages to the university, the Stella Burry Corporation, and federal corrections.

Recommendation: The expertise of the forensic team should be available for outpatient assessments.

Recommendation: Follow-up of clients who are released to the community should occur through case managers and in some cases by the Assertive Case Management Team. These clients also need additional supportive housing options.

It was agreed that regions should provide rural outreach services to clients but that regional efforts should be supported by the forensic team who should provide education, support and mentoring.

Dual Diagnosis:

The dual diagnosis clients are those people who have developmental delay as well as mental illness. The services that are seen as essential to meet the needs of this population includes an outreach team and primary and secondary services such as housing and case management.

Recommendation: Create an outreach team with a full-time coordinator and staff from a variety of disciplines including neuropsychology, psychiatry, occupational therapy, behaviour management specialist, social work, nursing and physiotherapy.

This team that has expertise in addressing this population must also be available to provide consultation throughout the province. The team also needs strong connection with community groups and government departments that have roles in services to this population.

Concurrent Disorders:

This category refers to those people who have mental illness and addiction problems. Humberwood is currently a facility that addresses this population, as does the Waterford Hospital addictions program.

It was agreed that local expertise is not feasible in relation to this specialized practice area thus access should be on a regional basis.

Recommendation: A treatment program for this population should include the following characteristics:

- *capacity for assessment and short term intensive treatment;*
- *well established links with HCS;*
- *regional level specialized team;*
- *rapid response capability.*

Eating Disorders:

Participants recognized that the numbers of people who require services for these disorders is typically small thus services are likely to remain fairly centralized. They did identify the need for staff who are properly trained to offer a response and they noted a need for the availability of provincial consultation. Regional psychiatric services were also highlighted as a need. This population was seen to need the range of services that are generally needed for mental health problems.

RECOMMENDED SERVICE DELIVERY MODEL FOR MENTAL HEALTH/ADDICTIONS SERVICES

There was emphasis on the importance of integrating the mental health service system within the primary health system. This type of integration includes the development of strong partnerships within health and community services and between the institutional health/long term care system and the community system.

The service system that is envisioned by the participants of the think tanks would best be described in the diagram below.

Tertiary Specialized Services in St. John's
↑
In-patient/Residential Regional Services
↑
Regional Mental Health/Addictions Services Team(s)
(Specialized interdisciplinary teams with generalist and specific specialist skills)
↑
Primary Health Care Teams (local level)
(Includes mental health counselor, addictions counselor, case manager)

This model must be implemented to fit the characteristics of each region. The modification of the model may result in a number of differences across the province such as: the creation of sub-regional mental health teams, reliance on St. John's for tertiary care and high level of regional self-sufficiency. The model is the preferred method of service delivery but it cannot be prescribed due to the diverse nature of the province.

CONCLUSION

Participants approached the think tank process with a full appreciation of fiscal realities and an expectation that their investment of time and resources would result in an improved system of mental health and addiction services. Their work resulted in a range of strategies that reflect their vision for the system as well as their expectation of what might be realistic in view of current budgets. Therefore, certain strategies could be implemented within present budgets while others will require additional resources.

However, participants emphasized the importance of the inter-relatedness of the strategy components. They indicated that implementation of this plan must occur with careful attention to all the factors that ensure success.

The strategy that is reflected in this document involves realignment and integration of several service elements, creation of new services and expansion of several exiting programs. These changes are all premised with a true commitment to meaningful involvement of consumers and their families, partnerships with the full array of agencies that contribute to mental health and support for the staff that will design and implement the strategy.

APPENDIX A

PARTICIPANT LIST

Think Tank Sessions
Official Participant List

Session 1: Child, Youth and Family Mental Health Services March 1		Session 2: Mental Health Services for Older Adults March 3	
Cathie Royle	Glenda Manning	Debbie Sue Martin	Linda Collingwood
Linda Carter	Susan Walsh	Erin Holland	Genevieve Corbin
Mona Romaine Elliott	Cathie Barker Pinsent	Brenda Wakeham	Diane Kieley
Kim St. John	Michelle Ryan	Connie Power	Cathy Baker
Paula Rogers	Bill Tucker	Roger Butler	Aldena Hillier-Legge
Dr. Oterino	Max King	Isabel Martins	Debbie Morris
Lloyd Wicks	Ian Shortall	Christine Caravan	Lorraine Best
Pauline Martino		Bernie Dunne	Lynn Bryant
Claudette Morris		Alice Kennedy	Lisa Hoddinott
Charlie Feltham		Judy Paul	M. Razi Sayeed
Deborah Perry		Pauline Martino	Michael G. Rayel
Presenters: Donna Ronan Olga Heath	Hubert White Donna McLennon	**Presenters**: Howard Strong Allan Bradley	

Think Tank Sessions
Official Participant List

Session 3: Integration of Mental Health & Addictions March 8	Session 4: Specialized Mental Health Services March 11 and 12	
Noreen Dort	Dennis Brothers	Judy Power
Mary Mayo	Una Tucker	Mary Dwyer
Doreen Chaulk	Harold Laite	Geralyn Dalton
Bill Tucker	Bernice Collins	Pam Elliott
Isobel Keefe	Ted Callanan	Debbie Sue Martin
Catherine Spinney	Pat Osmond	Andrea White
Zita White	Kevin Beamont	Kevin Hogan
Peggy Martin	Christine Pollett-Parsons	Deanne Costello
Lisa Goudie	Anne Porter	Tom Cantwell
Donna Luther	Judy O'Keefe	Doreen Chaulk
	Yvonne McDermott	Mary Mayo
	Jocelyn Greene	Donna Luther
	Peggy Martin	Donna Covey
Presenters: Kim Baldwin Catherine Spinney Zita White	**Presenters**: Peter Prendergast Judy Dale Roger Baggs	

Strategy Team (Present at every session):

Ellen Oliver
Joy Maddigan
Colleen Simms
John Collins
Moyra Buchan

APPENDIX B

THINK TANK EVALUATIONS

Workshop Evaluation

CYF Mental Health Services Think Tank

n = 22

1. To what extent did this workshop meet your expectations?

   2 less than I expected **15** what I expected **3** more than I expected

2. Rate your overall level of satisfaction by checking the appropriate number.

	Completely Dissatisfied		Neutral		Completely Satisfied
• content	1	2 **(1)**	3 **(5)**	4 **(12)**	5 **(4)**
• group size	1	2	3 **(2)**	4 **(12)**	5 **(8)**
• physical facilities	1	2 **(1)**	3 **(2)**	4 **(14)**	5 **(5)**
• AV materials	1	2 **(2)**	3 **(7)**	4 **(9)**	5 **(4)**
• group materials	1	2	3 **(7)**	4 **(10)**	5 **(5)**
• overall quality	1	2	3 **(3)**	4 **(14)**	5 **(5)**

3. The amount of information presented to me in the time available was:
   too much **(5)** about right **(15)** too little

4. Overall the facilitation was:
   14 very effective **7** adequate _____ ineffective

   Some participants were too dominant.

5. What aspect of the think tank did you find to be the most valuable?

   Others' perspectives and views; handouts in advance; small group discussion; amount of information; complexity of process; working groups; mental health people all in one room enjoyed; commonality of issues; presentations; everything; combination of participants.

6. What aspect of the think tank was least valuable for you?

   Nothing; presentations in the morning; not truly a provincial think tank; no Labrador and service users should have been included; didn't feel prepared for the task; not applicable – everything valuable; assign presenters to groups; coffee; need two days.

7. Did we achieve the goal of bringing together experts to ensure the provincial mental health strategy will provide appropriate direction to addictions services? Why/why not?

Hopefully our youth and children will benefit from something identified here today; "experts" only one piece of the puzzle – these comments shouldn't stand alone; no multi-cultural component; no, the end results too superficial and incomplete to be useful; good cross section of service providers; need more from regions; yes, an excellent step in improving the system; a good start; Yes!; yes, process should be successful; need to build on successes; some confusion as to purpose; yes, enormous task for time frame.

8. Do you have any suggestions for improving these think tanks?

Two day session; each facilitator report back; get service users involved; get true regional representation; get government to put the money into it; lacking many important issues due to lack of true provincial representation; simplify the process and walk people through the steps; notify participants ahead of time of the areas/questions so they may consult and bring issues to the table; space was an issue; one day probably too short; good format; no suggestions – well done! Table size for number of people should match.

Workshop Evaluation

Addictions Mental Health Services Think Tank

n = 13

1. To what extent did this workshop meet your expectations?

   _____ less than I expected __7__ what I expected __6__ more than I expected

2. Rate your overall level of satisfaction by checking the appropriate number.

	Completely Dissatisfied		Neutral		Completely Satisfied
• content	1	2	3	4 **(10)**	5 **(3)**
• group size	1	2 **(1)**	3 **(1)**	4 **(7)**	5 **(4)**
• physical facilities	1	2 **(1)**	3 **(4)**	4 **(5)**	5 **(3)**
• AV materials	1	2 **(1)**	3 **(8)**	4 **(2)**	5 **(2)**
• group materials	1	2	3 **(6)**	4 **(5)**	5 **(2)**
• overall quality	1	2	3	4 **(11)**	5 **(2)**

3. The amount of information presented to me in the time available was:
   too much **(1)** about right **(12)** too little

4. Overall the facilitation was:
   __12__ very effective __1__ adequate _____ ineffective

5. What aspect of the think tank did you find to be the most valuable?

   Challenged me to think differently; could articulate addictions issues; it broadened my knowledge of addictions services and was a great opportunity to network; group discussion; the fact we developed possible solutions rather than just rehashing all the information again; the richness of others experience, thinking and perspectives; discussions with people outside addictions – felt that there was a better appreciation; opportunity to bring forth ideas.

6. What aspect of the think tank was least valuable for you?

   It was all valuable; nothing; not enough time.

7. Did we achieve the goal of bringing together experts to ensure the provincial mental health strategy will provide appropriate direction to addictions services? Why/why not?

Yes, unfortunately weather played a role in keeping some away; yes; yes, glad to see consumers there; yes, confirmation that the strategy's six directions were broad enough to incorporate addictions services; need more additions representation; yes, ensuring addictions is on the agenda and not an add-on; yes, wide range of input from various services and individuals; certainly a great starting place - hoping this comes to effective fruition; yes; yes; yes, from many fields and services; yes.

8. Do you have any suggestions for improving these think tanks?

It was a very good day. Congratulations to the strategy team; great day, wonderful facilitation; would have been nice to have had lunch outside room; need two days; need time to step away, review and come back together. The issues are complex and the fear is that there isn't time to be comprehensive. It has given us the opportunity to sort out the needs of addictions within the mental health strategy; I need a second day to digest and reflect on what was discussed today; more time.

Workshop Evaluation

Seniors Mental Health Services Think Tank

n = 13

1. To what extent did this workshop meet your expectations?

   _____ less than I expected **11** what I expected **2** more than I expected

2. Rate your overall level of satisfaction by checking the appropriate number.

	Completely Dissatisfied		Neutral		Completely Satisfied
• content	1	2	3 **(2)**	4 **(9)**	5 **(2)**
• group size	1	2	3 **(1)**	4 **(8)**	5 **(4)**
• physical facilities	1	2 **(1)**	3 **(1)**	4 **(4)**	5 **(7)**
• AV materials	1	2	3 **(1)**	4 **(6)**	5 **(6)**
• group materials	1	2 **(1)**	3 **(1)**	4 **(5)**	5 **(6)**
• overall quality	1	2	3 **(2)**	4 **(8)**	5 **(3)**

3. The amount of information presented to me in the time available was:
   too much about right **(12)** too little **(1)**

4. Overall the facilitation was:
   10 very effective **3** adequate _____ ineffective

5. What aspect of the think tank did you find to be the most valuable?

   Group work; information exchange; Dr. Strong's presentation; learning from others; energy to move forward; hear different points of view; materials provided; the area on acute care services; organization of the entire day.

6. What aspect of the think tank was least valuable for you?

   Long day with much information to consume; need more focus on additions.

7. Did we achieve the goal of bringing together experts to ensure the provincial mental health strategy will provide appropriate direction to addictions services? Why/why not?

   8/13 say "Yes"; remains to be seen; missed key people due to lack of notice.

8. Do you have any suggestions for improving these think tanks?

   No (x4); good as is; want to be informed of direction the discussions will take; need more notice to prepare and make self available.

Workshop Evaluation

Specialized Mental Health Services Think Tank

n = 20

1. To what extent did this workshop meet your expectations?

   _____ less than I expected **13** what I expected **7** more than I expected

2. Rate your overall level of satisfaction by checking the appropriate number.

	Completely Dissatisfied		Neutral		Completely Satisfied
• content	1	2	3 **(3)**	4 **(9)**	5 **(8)**
• group size	1	2	3 **(2)**	4 **(10)**	5 **(8)**
• physical facilities	1	2 **(1)**	3 **(1)**	4 **(7)**	5 **(11)**
• AV materials	1	2	3 **(7)**	4 **(7)**	5 **(4)**
• group materials	1	2	3 **(6)**	4 **(9)**	5 **(5)**
• overall quality	1	2	3 **(2)**	4 **(9)**	5 **(9)**

3. The amount of information presented to me in the time available was:
   too much **(1)** about right **(18)** too little **(1)**

4. Overall the facilitation was:
   17 very effective **3** adequate _____ ineffective

5. What aspect of the think tank did you find to be the most valuable?

   Hearing we are on the same page. Knowing this is possible; large group discussion; small group work and fleshing out ideas; hearing regional perspectives and family/consumers; large group discussion was excellent; provincial sharing; intersectoral nature of small groups; informative; the fact is was provincial and almost all regions there; naming gaps; all beneficial; all valuable, enjoyed it all; it was all valuable; I would like to see psychiatrist from each region.

6. What aspect of the think tank was least valuable for you?

   None identified.

7. Did we achieve the goal of bringing together experts to ensure the provincial mental health strategy will provide appropriate direction to addictions services? Why/why not?

Yes, but still a lot of work to do; if ideas expressed here are supported then we have achieved our goal; not enough actual content experts; more clarity needed for specialized services in Waterford; yes, would like to see more regional experts; yes; yes; yes, except CYF; yes, now I feel a strategic plan is in our near future. Excellent consumer involvement.

8. Do you have any suggestions for improving these think tanks?

Improved acoustics; great process – now need to get it done; having break out groups in one room too noisy and distracting; great use of the time, very effective facilitation. I would like to see this happen again - hopefully when the strategy is rolled out and we can share achievements and monitor progress; Minister of Health and other politicians would benefit from this; good resources – Dr. Prendergast a great asset; another half day on how to operationalize after some synthesis would be helpful. Focused agenda in advance; need a follow up teleconference to clarify issues and recommendations once participants have had an opportunity to read the summary; would like to see results from all think tanks. Please include families whenever possible. We are often an under-utilized resource. We want to improve quality of life for our loved ones and we can help the experts do that! Excellent job. Purpose was accomplished. Common issues addressed and now feel part of the system. The linkage between us is essential. There are so few of us we need to know what each other is doing so we can support each other and stay connected. Two very good days. Congratulations to the organizing team!